CAREFIRST COMMERCIAL - NON-RISK - SPC

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Zelboraf

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Is this a request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐
2. What is the patient's diagnosis?
   - Cutaneous Melanoma (If checked, go to 3) ☐
   - Non-small cell lung cancer (NSCLC) (If checked, go to 3) ☐
   - Hairy cell leukemia (If checked, go to 3) ☐
   - Histiocytic neoplasms (If checked, go to 3) ☐
   - Thyroid carcinoma (papillary) (If checked, go to 3) ☐
   - Glioma (If checked, go to 3) ☐
   - Meningioma (If checked, go to 3) ☐
   - Astrocytoma (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) _____
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. What is the patient's diagnosis?
   - Cutaneous melanoma (If checked, go to 5) ☐
   - Non-small cell lung cancer (NSCLC) (If checked, go to 13) ☐
   - Hairy cell leukemia (If checked, go to 22) ☐

Histiocytic neoplasms (If checked, go to 27) ☐

Thyroid carcinoma (papillary) (If checked, go to 18) ☐

Glioma (If checked, go to 26) ☐

Meningioma (If checked, go to 26) ☐

Astrocytoma (If checked, go to 26) ☐

Other, please specify. (If checked, no further questions) _____

5. In which of the following settings will the requested medication be used?

Unresectable disease (If checked, go to 10) ☐

Metastatic disease (If checked, go to 10) ☐

Neoadjuvant treatment (If checked, go to 7) ☐

Adjuvant treatment (If checked, go to 6) ☐

Limited resectable local satellite/in-transit recurrent disease (If checked, go to 8) ☐

Other, please specify. (If checked, no further questions) _____

6. Does the patient have resected stage III disease? **Y** ☐ **N** ☐

7. Is immunotherapy contraindicated? **Y** ☐ **N** ☐

8. Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist) or dabrafenib/trametinib are less desirable based on side-effect profiles? **Y** ☐ **N** ☐

9. Will the requested medication be used in combination with cobimetinib (Cotellic)? **Y** ☐ **N** ☐

10. In what regimen will the requested medication be used?

In combination with cobimetinib (Cotellic) only (If checked, go to 12) ☐

In combination with cobimetinib (Cotellic) and atezolizumab (Tecentriq) (If checked, go to 12) ☐

In combination with cobimetinib (Cotellic) and atezolizumab and hyaluronidase-tqjs (Tecentriq Hybreza) (If checked, go to 12) ☐

As a single agent (If checked, go to 11) ☐

Other, please specify. (If checked, no further questions) _____

11. Is BRAF/MEK inhibitor combination therapy contraindicated? **Y** ☐ **N** ☐

12. Does the patient have BRAF V600 mutation-positive (e.g., BRAF V600E or V600K mutations) disease? ACTION REQUIRED: If Yes, please attach chart note(s) or test results of BRAF V600 mutation status.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

13. What is the clinical setting in which the requested medication will be used?

Advanced disease (If checked, go to 14) ☐

Recurrent disease (If checked, go to 14) ☐

Metastatic disease (If checked, go to 14) ☐

Other, please specify. (If checked, no further questions) _____

14. Is the disease BRAF V600E mutation-positive? ACTION REQUIRED: If Yes, please attach chart note(s) or test results of BRAF V600E mutation status.

Yes (If checked, go to 15) ☐

No (If checked, no further questions) ☐

Unknown or not available (If checked, no further questions) ☐

15. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

16. Was the combination of dabrafenib (Tafinlar) plus trametinib (Mekinist) not tolerated? **Y** ☐ **N** ☐

17. Has the patient experienced disease progression on BRAF-targeted therapy? **Y** ☐ **N** ☐

18. Will the requested medication be used for treatment of papillary thyroid carcinoma? **Y** ☐ **N** ☐

19. What is the clinical setting in which the requested medication will be used?

- Recurrent disease (If checked, go to 20) ☐
- Metastatic disease (If checked, go to 20) ☐
- Other, please specify. (If checked, no further questions) _____

20. Is the disease BRAF mutation-positive (e.g., BRAF V600E or V600K)? ACTION REQUIRED: If Yes, please attach chart note(s) or test results of BRAF mutation status.

- Yes (If checked, go to 21) ☐
- No (If checked, no further questions) ☐
- Unknown or not available (If checked, no further questions) ☐

21. Is the disease refractory to radioiodine (RAI) therapy? **Y** ☐ **N** ☐

22. What is the place in therapy in which the requested drug will be used?

- Initial therapy (If checked, go to 23) ☐
- Subsequent therapy (If checked, go to 25) ☐

23. What is the requested regimen?

- In combination with rituximab (e.g., Rituxan) (If checked, go to 24) ☐
- In combination with obinutuzumab (Gazyva) (If checked, go to 24) ☐
- Other, please specify. (If checked, no further questions) _____

24. Is the patient unable to tolerate purine analogs? **Y** ☐ **N** ☐

25. How will the requested medication be used?

- Single agent (If checked, no further questions) ☐
- In combination with rituximab (e.g., Rituxan) (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) _____

26. Is the disease BRAF V600 mutation-positive (e.g., BRAF V600E or V600K)? ACTION REQUIRED: If Yes, please attach chart note(s) or test results of BRAF V600 mutation status.

- Yes (If checked, no further questions) ☐
- No (If checked, no further questions) ☐
- Unknown or not available (If checked, no further questions) ☐

27. Is the disease BRAF V600 mutation-positive (e.g., BRAF V600E or V600K)? ACTION REQUIRED: If Yes, please attach chart note(s) or test results of BRAF V600 mutation status.

- Yes (If checked, go to 28) ☐
- No (If checked, no further questions) ☐
- Unknown or not available (If checked, no further questions) ☐

28. Will the requested medication be used for treatment of Erdheim-Chester disease or Langerhans cell histiocytosis? **Y** ☐ **N** ☐

29. Will the requested medication be used as single agent? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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