BlueCross BlueShield Federal Employee Program

BRAFTOVI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Braftovi (encorafenib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 540 capsules every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ capsules per 90 days
2. What is the patient's diagnosis?
   - ❑Metastatic colorectal cancer (CRC)
     a. Will Braftovi be used in combination with Erbitux (cetuximab)? ❑Yes ❑No
     b. Has the patient been on Braftovi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
     - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
       i. Does the patient have a documented BRAF V600E mutation as detected by an FDA-approved test? ❑Yes ❑No
       ii. Does the patient have wild-type BRAF colorectal cancer (CRC)? ❑Yes ❑No
       iii. Will Braftovi be used in combination with mFOLFOX6? ❑Yes ❑No*
       If NO, will Braftovi be used as first line therapy? ❑Yes ❑No
     - ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
       i. Has the patient had any disease progression or unacceptable toxicity while on Braftovi? ❑Yes ❑No
   - ❑Metastatic non-small cell lung cancer (NSCLC)
     a. Will Braftovi be used in combination with Mektovi (binimetinib)? ❑Yes ❑No
     b. Has the patient been on Braftovi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
     - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
       i. Does the patient have a documented BRAF V600E mutation as detected by an FDA-approved test? ❑Yes ❑No
       ii. Does the patient have wild-type BRAF non-small cell lung cancer (NSCLC)? ❑Yes ❑No
     - ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
       i. Has the patient had any disease progression or unacceptable toxicity while on Braftovi? ❑Yes ❑No
   - ❑Unresectable or metastatic melanoma
     a. Will the Braftovi be used in combination with Mektovi (binimetinib)? ❑Yes ❑No
     b. Has the patient been on Braftovi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
     - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
       i. Does the patient have a documented BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test? ❑Yes ❑No
       ii. Does the patient have wild-type BRAF melanoma? ❑Yes ❑No
     - ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
       i. Has the patient had any disease progression or unacceptable toxicity while on Braftovi? ❑Yes ❑No
   - ❑None of the above
3. Does the prescriber agree to monitor the patient for the following: tumor promotion in BRAF wild-type tumors, hemorrhage, uveitis, QT prolongation and embryo-fetal toxicity? ❑Yes ❑No
4. Does the physician agree to perform a dermatologic evaluation every two months while on therapy and for up to six months following discontinuation of therapy? ❑Yes ❑No