BlueCross BlueShield

MEKINIST 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

Federal Employee Program, **PRIOR APPROVAL REQUEST** 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 complete	ed form.			F	ax: 1-877-378-472
Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: DMal	e 🛛 Female	Office Phone:	Office Fax	x:
Street Address:	·		Office Street Address:	•	
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
		PHYSICIAN	COMPLETES		

Mekinist (trametinib)

**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

1. Has the patient been on Mekinist continuously for the last 6 months , <u>excluding samples</u> ? <i>Please select answer below:</i>				
TYES – this is a PA renewal for CONTINUATION of therapy, please answer the questions on PAGE 3				
NO – this is INITIATION of therapy, please answer the questions below:				
2. Is this request for brand or generic? Brand Generic				
3. Will the patient need more than 2 milligrams per day? □Yes* □No <i>*If YES</i> , please specify the requested quantity: milligrams per day				
4. What is the patient's diagnosis?				
□Locally advanced Anaplastic Thyroid Cancer (ATC) <u>OR</u> □Metastatic Anaplastic Thyroid Cancer (ATC)				
a. Does the patient have a documented BRAF V600E mutation? \Box Yes \Box No				
b. Are there any satisfactory locoregional treatment options? Yes No				
c. Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No				
Low-Grade Glioma (LGG)				
a. Does the patient have a documented BRAF V600E mutation? \Box Yes \Box No				
b. Does the patient require systemic therapy? Yes No				
c. Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No				
Low-grade serous ovarian cancer				
a. Will Mekinist be used a single agent (monotherapy) for persistent or recurrent disease? Yes No				
Detastatic melanoma OR Durresectable melanoma				
a. Does the patient have a documented BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test? □Yes □No				
b. Will Mekinist be used as a single agent (monotherapy)? Yes No				
c. Will Mekinist be used in combination with Tafinlar (dabrafenib)? UYes No				
Resectable melanoma				
a. Does the patient have a documented BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test? □Yes □No				
b. Does the patient's melanoma have lymph node involvement? Yes No				
c. Will Mekinist be used as adjuvant treatment after complete resection? Yes No				
d. Will Mekinist used in combination with Tafinlar (dabrafenib)? UYes No				

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

PAGE 1 of 3



MEKINIST

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PAGE 2 – PHYSICIAN COMPLETES				
Patient Name:	DOB:	Pati	ent ID: R	
 Metastatic Non-Small Cell Lung a. Does the patient have a docu b. Will Mekinist be used in con Metastatic solid tumors <u>OR</u> 	mented BRAF V600E mutatio		an FDA-approved test? □Yes □No	□No
a. Has the patient's condition pb. Are there any satisfactory altc. Does the patient have a docu	ernative treatment options? \Box	Yes DNo	□No No	
 d. Will Mekinist be used in con □Other diagnosis (<i>please specify</i>): 	nbination with Tafinlar (dabraf	enib)? D Yes		

5. **FEMALE Patient**: Is the patient of reproductive potential? □Yes* □No

**If YES*, will the patient be advised to use effective contraception during treatment with Mekinist and for four months after the last dose? □Yes □No

PAGE 2 of 3

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Mekinist – FEP MD Fax Form Revised 7/26/2024



Federal Employee Program.

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Patient Information (required)		Provider Information (required)			
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: DMale	Female	Office Phone:	Office Fax	::
Street Address:			Office Street Address:	· · · ·	
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R		1 1	Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Mekinist (trametinib)

**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

 Has the patient been on Mekinist continuously for the last 6 months, <u>excluding samples</u>? <i>Please select answer below:</i> NO – this is INITIATION of therapy, please answer the questions on <u>PAGE 1</u> YES – this is a PA renewal for CONTINUATION of therapy, please answer the questions below:
2. Is this request for brand or generic? Brand Generic
3. Will the patient need more than 2 milligrams per day? □Yes* □No <i>*If YES</i> , please specify the requested quantity: milligrams per day
4. What is the patient's diagnosis?
□Locally advanced Anaplastic Thyroid Cancer (ATC) <u>OR</u> □Metastatic Anaplastic Thyroid Cancer (ATC) a. Will Mekinist be used in combination with Tafinlar (dabrafenib)? □Yes □No
□Low-Grade Glioma (LGG)
a. Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No
□Low-grade serous ovarian cancer
a. Will Mekinist be used a single agent (monotherapy) for persistent or recurrent disease? Yes No
□Metastatic melanoma <u>OR</u> Unresectable melanoma
a. Will Mekinist be used as a single agent (monotherapy)? Yes No*
*If NO, will Mekinist be used in combination with Tafinlar (dabrafenib)? \Box Yes \Box No
□Metastatic Non-Small Cell Lung Cancer (NSCLC)
a. Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No
□Metastatic solid tumors OR □Unresectable solid tumors
a. Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No
Other diagnosis (<i>please specify</i>):

5. Has the patient experienced disease progression or unacceptable toxicity while on Mekinist? \Box Yes \Box No

6. FEMALE Patient: Is the patient of reproductive potential? □Yes* □No
*If YES, will the patient be advised to use effective contraception during treatment with Mekinist and for four months after the last dose? □Yes □No



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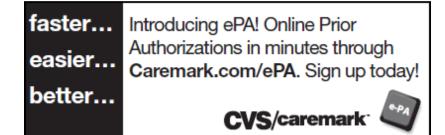
Message:

Attached is a Prior Authorization request form.

Federal Employee Program.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM- 9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>



The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** Lertify all information provided on this form to be true and correct to the best of my knowledge and belief. Lunderstand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and l agree to provide any such information to the insurer. Mekinist – FEP MD Fax Form Revised 7/26/2024