BlueCross BlueShield Federal Employee Program

MEKINIST
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 completed form.

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

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					

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**, excluding samples? ***Please select answer below:***
   ❑**YES** – 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
   If YES, please specify the requested quantity: _____ milligrams per day
4. What is the patient's diagnosis?
   ❑Locally advanced Anaplastic Thyroid Cancer (ATC) **OR** ❑Metastatic Anaplastic Thyroid Cancer (ATC)
   a. Does the patient have a documented BRAF V600E mutation? ❑Yes ❑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? ❑Yes ❑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

   ❑Metastatic melanoma **OR** ❑Unresectable 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)? ❑Yes ❑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)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Metastatic Non-Small Cell Lung Cancer (NSCLC)

a. Does the patient have a documented BRAF V600E mutation as detected by an FDA-approved test? ❑Yes ❑No

b. Will Mekinist be used in combination with Tafinlar (dabrafenib)? ❑Yes ❑No

❑Metastatic solid tumors **OR** ❑Unresectable solid tumors

a. Has the patient's condition progressed following prior treatment? ❑Yes ❑No

b. Are there any satisfactory alternative treatment options? ❑Yes ❑No

c. Does the patient have a documented BRAF V600E mutation? ❑Yes ❑No

d. Will Mekinist be used in combination with Tafinlar (dabrafenib)? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

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

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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					

CONTINUATION OF THERAPY (PA RENEWAL)

Mekinist (trametinib)

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

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1. Has the patient been on Mekinist continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**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
   If YES, please specify the requested quantity: _____ milligrams per day

4. What is the patient's diagnosis?
   ❑Locally advanced Anaplastic Thyroid Cancer (ATC) **OR** ❑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 **OR** 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)? ❑Yes ❑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 ***(please specify)***: _____

5. Has the patient experienced disease progression or unacceptable toxicity while on Mekinist? ❑Yes ❑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.

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. ***Please only fax the completed form once as duplicate submissions may delay processing times.***