CVS caremark™ {{PANUMCODE}}

Tafinlar

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Melanoma BRAF V600 activating mutation-positive
   - ❑ Non-small cell lung cancer, BRAF V600E mutation-positive
   - ❑ Anaplastic thyroid cancer (ATC), BRAF V600E mutation-positive
   - ❑ Glioma, BRAF V600 mutation-positive
   - ❑ Meningioma, BRAF V600 mutation-positive
   - ❑ Astrocytoma, BRAF V600 mutation-positive
   - ❑ Follicular thyroid carcinoma, BRAF mutation positive
   - ❑ Hurthle cell thyroid carcinoma, BRAF mutation positive
   - ❑ Papillary thyroid carcinoma, BRAF mutation positive
   - ❑ Hepatobiliary cancers (gallbladder cancer, extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma)
   - ❑ Histiocytic neoplasms
   - ❑ Treatment of cutaneous melanoma
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following questions if the diagnosis is cutaneous melanoma. If diagnosis is NOT cutaneous melanoma, please skip to #8.

3. The preferred products for your patient's health plan are: Braftovi, Cotellic, Mektovi, and Zelboraf. Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017***
   - ❑ Yes - Braftovi
   - ❑ Yes - Cotellic
   - ❑ Yes - Mektovi
   - ❑ Yes - Zelboraf
   - ❑ No - continue request for non-preferred product
4. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #6*

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5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #8*

6. Is the requested product being used for adjuvant treatment? *If Yes, skip to #8* ❑ Yes ❑ No

7. Does the patient have a documented inadequate response or intolerable adverse event to ANY of the preferred products? *Indicate ALL that apply.* ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***

❑ Yes - Braftovi	❑ Inadequate response	❑ Intolerable adverse event
❑ Yes - Cotellic	❑ Inadequate response	❑ Intolerable adverse event
❑ Yes - Mektovi	❑ Inadequate response	❑ Intolerable adverse event
❑ Yes - Zelboraf	❑ Inadequate response	❑ Intolerable adverse event

❑ None of the above

8. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #12*

9. Is there evidence of unacceptable toxicity or disease progression or recurrence while on the current regimen? ❑ Yes ❑ No

10. Is this request for the adjuvant treatment of cutaneous melanoma? ❑ Yes ❑ No *If No, no further questions*

11. How many months of therapy has the patient received? _____ months *No further questions*

12. What is the patient's mutation status? ***ACTION REQUIRED: Please attach documentation of mutation status.***
    - ❑ BRAF V6000 positive
    - ❑ BRAF V6000 negative
    - ❑ BRAF V600E positive
    - ❑ BRAF V600E negative
    - ❑ Unknown or not available

13. How will the requested medication be given? ***Indicate ALL that apply.***
    - ❑ As a single agent
    - ❑ In combination with Mekinist (trametinib)
    - ❑ None of the above

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Melanoma

14. In what setting will the requested medication be used?
    - ❑ Adjuvant treatment of cutaneous melanoma
    - ❑ Treatment of unresectable cutaneous melanoma*, no further questions*
    - ❑ Treatment of metastatic cutaneous melanoma*, no further questions*
    - ❑ Treatment of brain metastases from melanoma*, no further questions*
    - ❑ None of the above

15. Does the patient have stage III disease? ❑ Yes ❑ No

16. Has the patient had a complete resection? *If Yes, no further questions* ❑ Yes ❑ No

17. Does the patient have evidence of disease? ❑ Yes ❑ No

Section B: Non-Small Cell Lung Cancer

18. Does the patient have recurrent, advanced, or metastatic disease? ❑ Yes ❑ No

Section C: Anaplastic Thyroid Cancer

19. Is the disease locally advanced or metastatic? ❑ Yes ❑ No

Section D: Thyroid Carcinoma

20. Is the disease progressive and/or symptomatic? ❑ Yes ❑ No

21. Is the thyroid carcinoma not amendable to radioiodine (RAI) therapy? ❑ Yes ❑ No

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Section E: Hepatobiliary Cancers (Gallbladder Cancer, Extrahepatic Cholangiocarcinoma, Intrahepatic Cholangiocarcinoma)

22. In which line of therapy will the requested medication be used?
    - ❑ First line therapy
    - ❑ Subsequent therapy

23. Will the requested medication be used for progressive unresectable or metastatic disease? ❑ Yes ❑ No

Section F: Histiocytic Neoplasms

24. Will the requested medication be used for treatment of Erdheim-Chester disease or Langerhans cell histiocytosis?
    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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