

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

**Braftovi**  
**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.

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**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?  
 Cutaneous melanoma  
 Glioma  
 Meningioma  
 Astrocytoma  
 Colorectal cancer  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is this a request for continuation of therapy with the requested drug?  
 Yes  No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?  
 Yes  No *No further questions*

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

**Section A: Cutaneous Melanoma**

5. Is the disease unresectable or metastatic?  Yes  No
6. Will the requested medication be used in combination with binimetinib (Mektovi)?  Yes  No
7. Does the patient have BRAF V600E or V600K mutations? **ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.**  Yes  No

**Section B: Glioma, Meningioma, and Astrocytoma**

8. What is the patient's BRAF V600 mutation status (e.g., BRAF V600E or V600K)? **ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.**  Positive  Negative  Unknown or not available

**Section C: Colorectal Cancer**

9. Is the disease advanced or metastatic?  Yes  No

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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10. Will Braftovi be used in combination with either cetuximab (Erbitux) or panitumumab (Vectibix)?  
 Yes  No
11. Will Braftovi be used as subsequent therapy?  Yes  No
12. What is the patient's BRAF V600E mutation status? ***ACTION REQUIRED: Please attach documentation of BRAF V600E mutation status.***  Positive  Negative  Unknown or not available

***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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