CVS caremark™ {{PANUMCODE}}

Mekinist

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
   - ❑ 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
   - ❑ Brain cancer with neurofibromatosis type 1
   - ❑ Uveal melanoma
   - ❑ 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 #7*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
5. Is this request for the adjuvant treatment of cutaneous melanoma? ❑ Yes ❑ No *If No, no further questions*
6. How many months of therapy has the patient had? _____ months
7. How will the requested medication be given?
   - ❑ As a single agent
   - ❑ In combination with Tafinlar (dabrafenib)
   - ❑ In combination with dabrafenib (Tafinlar) and either cetuximab or panitumumab
   - ❑ Other _____
8. 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

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

9. Is the disease:
   ❑ Advanced ❑ Unresectable advanced ❑ Unresectable ❑ Recurrent ❑ Metastatic
   ❑ Other _____

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

Section A: Melanoma

10. What is the intent of treatment?
    ❑ Adjuvant treatment of cutaneous melanoma
    ❑ Treatment of unresectable or metastatic cutaneous melanoma*, no further questions*
    ❑ Treatment of brain metastases from melanoma*, no further questions*
    ❑ None of the above

11. Will the patient be using the requested medication following complete lymph node dissection/resection or recurrence? ❑ Yes ❑ No

Section B: Colorectal Cancer

12. Will Mekinist be used as subsequent therapy? ❑ 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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