

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



{{PANUMCODE}}

Mektovi

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}}

- What is the patient's diagnosis?
 Cutaneous melanoma Glioma
 Meningioma Astrocytoma
 Other _____
- What is the ICD-10 code? _____
- Is the disease:
 Unresectable advanced Unresectable Metastatic Other _____
- Is this a request for continuation of therapy with the requested drug?
 Yes No *If No, skip to diagnosis section.*
- 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

- Will the requested medication be used in combination with Braftovi (encorafenib)? Yes No
- Does the patient have BRAF V600E or V600K mutations? **ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.** Yes No Unknown or not available

Section B: Glioma, Meningioma, Astrocytoma

- 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

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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Mektovi SGM - 8/2020.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com