Braftovi (encorafenib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Locally advanced melanoma ☐ Unresectable melanoma ☐ Metastatic melanoma ☐ Metastatic colorectal cancer ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

<u>For Melanoma diagnoses, answer the following</u>:

Does patient have a BRAF V_{600E} mutation? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have a BRAF V_{600K}mutation? ☐ Yes ☐ No *Please submit chart documentation.*

Does patient have both BRAF V_{600E} and a BRAF V_{600K}mutation? ☐ Yes ☐ No *Please submit chart documentation.*

Is patient's tumor Stage IIIB, IIIC, or IV? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient been previously treated for their melanoma? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient failed on only one previous first-line immunotherapy? ☐ Yes ☐ No *Please submit chart documentation*

Has patient been previously treated with a BRAF inhibitor? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient been previously treated with a MEK inhibitor? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient been previously treated with a systemic chemotherapy? ☐ Yes ☐ No *Please submit chart documentation.*

Will patient be treated with Mekovi in combination with Braftovi? ☐ Yes ☐ No

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

For Metastatic colorectal diagnosis, answer the following:

Does patient have a BRAF V_{600E} mutation? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient progressed after only one and no more than two previous treatment regimens? □ **Yes** □ **No**

Please submit chart documentation.

Has patient been previously treated with a BRAF inhibitor? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient been previously treated with a MEK inhibitor? □ **Yes** □ **No** ***Please submit chart documentation.***

Has patient been previously treated with an EGFR inhibitor? □ **Yes** □ **No** ***Please submit chart documentation***

Will Braftovi be used in combination with the EGFR inhibitor Erbitux® (cetuximab)? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811