Mekinist (trametinib)
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** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

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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:**
□ Melanoma □ High Grade Glioma □ Low Grade Glioma □ Other diagnosis: _____ICD-10:_____	

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

Clinical Information:

Will patient use the requested drug in conjunction with a clinical trial? □ Yes □ No

Is the patient positive for a BRAF V600E or V600K mutation?* □ Yes □ No **Test results must be provided.*

<u>For diagnosis of melanoma, answer the following:</u>

Does the patient have a diagnosis of unresectable or stageIV melanoma? □ Yes □ No Please provide documentation.

Does patient have Stage III melanoma? □ Yes □ No Please provide documentation.

Has patient's Stage III melanoma undergone complete resection? □ Yes □ No Please provide documentation.

Has the patient received prior BRAF-inhibitor therapy, such as Zelboraf (vemurafenib) or Tafinlar (dabrafenib)? □ Yes □ No Please provide documentation.

<u>For diagnosis of High Grade or Low Grade Glioma, answer the following:</u>

Does patient have a diagnosis of BRAF V600 mutant High Grade glioma(HGG) that has relapsed, progressed or failed to respond to frontline therapy? □ Yes □ No Please provide documentation.

Does patient have a diagnosis of BRAF V600 mutant Low Grade glioma(LGG) with progressive disease following surgical excision? □ Yes □ No Please provide documentation.

Is patient a non-surgical candidate with necessity to begin first systemic treatment because of a risk of neurological impairment with progression? □ Yes □ No Please provide documentation.

Does patient have confirmed measurable disease? □ Yes □ No Please provide documentation.

Has patient been previously treated with dabrafenib, trametinib, other RAF inhibitors, other MEK or ERK inhibitors? □ Yes □ No Please provide documentation.

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If LGG patient, has patient been previously treated w any systemic therapy or radio-therapy? □ Yes □ No Please provide documentation

Will Tafinlar (dabrafenib)/Mekinist (trametinib) combination therapy be used for the glioma treatment? □ Yes □ No Please provide documentation

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: _____

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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

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