PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function

Braftovi™ + Mektovi® (encorafenib / binimetinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Braftovi 50 mg capsule
- ☐ Braftovi 75 mg capsule
- ☐ Mektovi 15 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Braftovi + Mektovi is limited to a 14-day supply at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

Patient must have one of the following diagnoses and meet the corresponding criteria:

1. Unresectable or metastatic BRAFV600E or BRAFV600K mutation-positive melanoma as detected by an FDA-approved test
2. May not be used in patients who have been previously treated with a BRAF- or MEK-inhibitor therapy
3. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1
4. Must be using both Braftovi and Mektovi in combination

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

If approved, authorization for Braftovi + Mektovi will be initially allowed for 12 months.

For continuation, patient must have met the following requirements:

1. The patient has not experienced disease progression
2. The patient is compliant in taking the medication as scheduled
3. The patient tolerated the medication

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2018

Last reviewed 11/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ $BRAF^{V600E}$ or $BRAF^{V600K}$ mutation-positive unresectable or metastatic melanoma (documentation of the mutation-positive test result must be submitted to Priority Health)
- ☐ *Other – the patient's condition is:* _____

B. What is the patient's ECOG performance status?

- ☐ 0: Fully active, able to carry on all pre-disease performance without restriction
- ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
- ☐ 2: Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
- ☐ 3: Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- ☐ 4: Completely disabled; cannot carry on any self-care; totally confined to bed or chair

C. Has the patient used any of the following therapies in the past?

- ☐ Tafinlar
- ☐ Zelboraf
- ☐ Mekinist
- ☐ Cotellic
- ☐ None of the above

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Has the patient experienced disease progression?

- ☐ No
- ☐ *Yes; rationale for use:* _____

B. Is the patient compliant in taking the medications?

- ☐ Yes
- ☐ *No; rationale for use:* _____

C. Is the patient tolerating the medications?

- ☐ Yes
- ☐ *No; rationale for use:* _____

Additional information

Note: For Medicaid members, Mektovi is carved-out to the State of Michigan. Authorization for coverage of Braftovi will require documentation that the State of Michigan has authorized coverage of Mektovi.

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Last reviewed 11/2018