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.

Cotellic™ (cobimetinib)

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: ☐ Cotellic 20 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Patient must meet all of the following criteria:

1. Must have unresectable or metastatic melanoma with a BRAF V600E or V600K mutation
   - Confirmation of mutation required using an FDA-approved test, such as THxID BRAF test, a diagnostic test manufactured by bioMérieux
   - Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.
2. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1
3. Must be used in combination with Zelboraf

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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Unresectable or metastatic melanoma
  - ☐ BRAF V600E mutation-positive melanoma confirmed by laboratory testing
  - ☐ BRAF V600K mutation-positive melanoma confirmed by laboratory testing
  - ☐ Wild-type disease
- ☐ *Other – the patient's condition is:* _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2016

Last reviewed 01/2020

B. What is the patient's ECOG performance status (i.e. 0 – 4)? _____ (see additional information for descriptions)

C. Will the patient be using Cotellic concurrently with Zelboraf?

☐ Yes ☐ No

Additional information

Eastern Cooperative Oncology Group (ECOG) performance status descriptions:

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

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