Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Mekinist® (trametinib)

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: ☐ Mekinist 0.5 mg tablet ☐ Mekinist 2 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
2. Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 - 2
3. For melanoma and non-small cell lung cancer (NSCLC), must not have prior use of a BRAF or MEK inhibitor

Additional information

Note: When criteria are met, duration of approval will be 1 year. Mekinist 0.5mg tablets are limited to a quantity of 90 tablets per 30 days. Mekinist 2mg tablets are limited to a quantity of 30 tablets per 30 days.

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication for a drug or biologic used in an anti-cancer chemotherapeutic regimen is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019

- supported by one of the following references (known as compendia): National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Micromedex DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology, or Lexi-Drugs
- — *or* — supported in peer-reviewed medical literature appearing in regular editions of approved publications

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Malignant melanoma
  - ☐ Unresectable or metastatic with BRAF V600E or V600K mutations detected by an FDA-approved test
  - ☐ As adjuvant treatment for BRAF V600E or V600K mutations detected by an FDA-approved test in combination with Tafinlar
- ☐ Non-small cell lung cancer (metastatic) with BRAF V600E mutations detected by an FDA-approved test and in combination with Tafinlar
- ☐ Anaplastic thyroid cancer (locally advanced or metastatic) with BRAF V600E mutations, no satisfactory locoregional treatment options, and in combination with Tafinlar
- ☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

B. Is the patient's ECOG performance status 0 - 2?

- ☐ Yes.
  - ☐ 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

- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

C. For melanoma and non-small cell lung cancer, has the patient used any BRAF or MEK inhibitors in the past?

- ☐ No
- ☐ Yes. *Check all that apply:*
  - ☐ Tafinlar
  - ☐ Zelboraf
  - ☐ Braftovi
  - ☐ Mektovi
  - ☐ Cotellic

Are you requesting an exception to the criteria?

- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

D. Will Mekinist be used as a single-agent or in combination?

- ☐ Single-agent
- ☐ Combination therapy with Tafinlar (dabrafenib)
- ☐ Combination therapy with *other – please list*: _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Mekinist likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Mekinist, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 01/2019