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.

Tafinlar® (dabrafenib)

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:
☐ Tafinlar 50 mg capsule
☐ Tafinlar 75 mg capsule

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.

1. Must be used for a medically-accepted indication*
2. Must have documentation of $BRAF^{V600}$ mutation status, as detected by an FDA-approved test
3. Patient must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2
4. May not be used in patients who have previously used Zelboraf or Mekinist

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.)
- 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

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 09/2018
Last reviewed 09/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Malignant melanoma ***(check all that apply)***
  - ☐ $BRAF^{V600}$ mutation-positive disease confirmed by an FDA-approved test
  - ☐ Wild-type (no BRAF mutation) disease
  - ☐ Unresectable or metastatic disease
  - ☐ With lymph node involvement following complete resection

- ☐ Metastatic Non-Small Cell Lung Cancer
  - ☐ $BRAF^{V600E}$ mutation-positive disease confirmed by an FDA-approved test
  - ☐ Wild-type (no BRAF mutation) disease

- ☐ Locally advanced or metastatic anaplastic thyroid carcinoma
  - ☐ $BRAF^{V600E}$ mutation-positive disease confirmed by an FDA-approved test
  - ☐ Wild-type (no BRAF mutation) disease
  - ☐ No satisfactory locoregional treatment options

- ☐ Malignant melanoma
  - ☐ $BRAF^{V600}$ mutation-positive disease confirmed by an FDA-approved test
  - ☐ Wild-type (no BRAF mutation) disease

- ☐ *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?

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

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

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

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Last reviewed 09/2018

Priority Health Medicare Exception Requests

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

_____

_____

If the patient is currently using Tafinlar, 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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Updated 09/2018
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