

Please Note: Medical Necessity Prior Authorization may be overridden for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

## PRIOR AUTHORIZATION **BYPASS**

### **Tafinlar® (dabrafenib)**

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs



Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx**

MD \_\_\_\_\_  
 Signature \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_

**Rx COMPLETE PRIOR AUTHORIZATION FORMS**

*as directed by physician*

**Dx: MELANOMA**

MD \_\_\_\_\_  
 Signature **ICD 10: C 43.9** \_\_\_\_\_

# SAMPLE



**Prescriber Information**

<b>Last Name:</b> <input type="text"/> <b>DEA/NPI:</b> <input type="text"/> <b>Phone</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>Specialty:</b> <input type="text"/> <b>Fax</b> <input type="text"/>
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**Member Information**

<b>Last Name:</b> <input type="text"/> <b>Member ID Number</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>DOB:</b> <input type="text"/>
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**Medication Information:**

<b>Drug Name and Strength:</b> <input type="text"/> <b>Diagnosis:</b> <input type="text"/>	<b>Quantity and Dosing:</b> <input type="text"/> <b>Duration:</b> <input type="text"/>
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When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

**Tafinlar (dabrafenib) Prior Authorization Form**

You must answer ALL of the following questions		
1. Is the patient at least 18 years of age or older?	Y	N
2. Does the patient have a diagnosis of unresectable or metastatic melanoma?	Y	N
3. Is the patient BRAF <sup>V600E</sup> or BRAF <sup>V600K</sup> mutation positive? <i>Please provide documentation.</i>	Y	N
4. Does the patient have wild-type BRAF melanoma?	Y	N
5. Has the patient previously received treatment with Zelboraf (vemurafenib)?	Y	N
6. Has the patient previously received treatment with Mekinist (trametinib) monotherapy?	Y	N

**Please note, not all drugs/diagnoses are covered on all plans.**

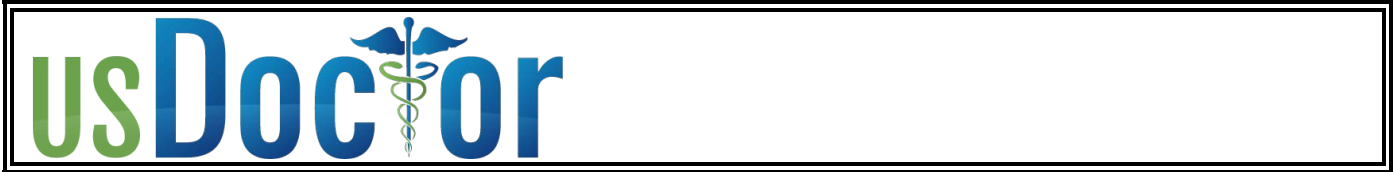
Comments: \_\_\_\_\_  
 Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

\_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Medical Staff – Name/Title**



**Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.**

**I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**



**Contact Information:**

Telephone: (855)251.9116

Fax: (248)593.9575

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**PRIOR AUTHORIZATION FORM:  
COVER PAGE**

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-10	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
<b>Medication/Failure Reason:</b>			
IgE: _____ ESR: _____      CRP: _____      # Joints: _____      %BSA: _____ Height: _____      Weight: _____      BMI: _____ HA1C: _____      Hemoglobin: _____      Hematocrit: _____      T-Score: _____ Dialysis: _____      Long Term Care Facility: _____      Self Injecting: _____ Stimulation test: _____ / _____      Growth velocity: _____      #Chemotherapy cycles/month: _____ Mini-Mental Status Test: _____      Baseline Free testosterone/Total testosterone: _____ / _____ HCV RNA viral load: _____      Viral Genotype: _____      ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function  <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	
The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message.			