OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare
# Tafinlar® (Dabrafenib) Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

## Drug Information

***Pharmacy billing (NDC:*** _____***) Start Date (or date of next dose):*** _____

***Dose:*** _____ ***Regimen:*** _____

## Billing Provider Information

***Pharmacy NPI:*** _____ ***Pharmacy Name:*** _____

***Pharmacy Phone:*** _____ ***Pharmacy Fax:*** _____

## Prescriber Information

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

## Criteria

***Page 1 of 2–Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Please indicate the diagnosis and information:

☐ **Unresectable or metastatic melanoma**
- A. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
- B. Does member have wild-type BRAF melanoma? Yes ☐ No ☐
- C. Will dabrafenib be used as a single-agent? Yes ☐ No ☐
- D. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes ☐ No ☐
- E. Will dabrafenib be used as first-line therapy? Yes ☐ No ☐
- F. Will dabrafenib be used as second-line or subsequent therapy? Yes ☐ No ☐
  - i. If using as second-line or subsequent therapy, please provide member's ECOG performance status (0-5):_____

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is the diagnosis refractory or metastatic disease? Yes ☐ No ☐
- B. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
- C. Does member have wild-type BRAF NSCLC? Yes ☐ No ☐
- D. Will dabrafenib be used as a single-agent? Yes ☐ No ☐
- E. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes ☐ No ☐

☐ **Anaplastic Thyroid Cancer (ATC)**
- A. Is the diagnosis locally advanced or metastatic disease? Yes ☐ No ☐
- B. Does member have BRAF V600E mutation? Yes ☐ No ☐
- C. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes ☐ No ☐
- D. Are there any satisfactory locoregional treatment options for the member? Yes ☐ No ☐

☐ **Solid Tumor**
- A. Is the diagnosis metastatic disease? Yes ☐ No ☐
- B. Does the member have a BRAF V600E mutation? Yes ☐ No ☐
- C. Has member progressed on prior therapies with no satisfactory alternative treatment options? Yes ☐ No ☐
- D. Will dabrafenib be used in combination with trametinib? Yes ☐ No ☐





<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA Health Care Authority

# State of Oklahoma
# SoonerCare
# Tafinlar® (Dabrafenib) Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

## Criteria

***Page 2 of 2– Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.***

1. Please indicate the diagnosis and information (continued):

☐ **Low-Grade Glioma (LGG)**
   A. Does member have BRAF V600E mutation? Yes☐ No☐
   B. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes☐ No☐

☐ If diagnosis is not listed above, please indicate diagnosis: _____

**For Initial Authorization, continued:**

Additional Information: _____
_____
_____



**For Continued Authorization:**
1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on dabrafenib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to dabrafenib therapy? Yes☐ No☐
   *If yes, please specify adverse reactions:* _____

Additional Information: _____
_____
_____


**Please complete and return all pages. Failure to complete all pages will result in processing delays.**

**Prescriber Signature:** _____ **Date:** _____
***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*** *Please do not send in chart notes. Specific information will be requested if necessary.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |