

**Braftovi<sup>®</sup> (encorafenib) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Drug Information****Pharmacy billing (NDC:** \_\_\_\_\_ **) Start Date:** \_\_\_\_\_**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_**Pharmacy Information****Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_**Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_**Prescriber Information****Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_**Criteria****For Initial Authorization:**

1. Does member have BRAF V600E or V600K mutation? Yes \_\_\_ No \_\_\_

2. Please indicate the diagnosis and information:

 **Melanoma**

A. Is diagnosis unresectable or metastatic melanoma? Yes \_\_\_ No \_\_\_

B. Will encorafenib be used in combination with binimetinib? Yes \_\_\_ No \_\_\_

 **Colorectal Cancer (CRC)**

A. Is diagnosis advanced or metastatic CRC? Yes \_\_\_ No \_\_\_

B. Will encorafenib be used in combination with cetuximab or panitumumab? Yes \_\_\_ No \_\_\_

C. Will encorafenib be used with or without fluorouracil-based chemotherapy? Yes \_\_\_ No \_\_\_

 **Non-Small Cell Lung Cancer (NSCLC)**

A. Is diagnosis metastatic NSCLC? Yes \_\_\_ No \_\_\_

B. Will encorafenib be used in combination with binimetinib? Yes \_\_\_ No \_\_\_

 If answer is none of the above, please indicate diagnosis: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does patient have any evidence of progressive disease while on encorafenib therapy? Yes \_\_\_ No \_\_\_

3. Has the member experienced any adverse drug reactions related to encorafenib therapy? Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

**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:University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE*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.*