

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:** _____

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 (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 a 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? 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 yes, 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 a 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? Yes___ No___

Thyroid Cancer

- a. Is the diagnosis locally advanced or metastatic disease? Yes___ No___
- b. Does member have a BRAF V600E mutation? Yes___ No___
- c. Will dabrafenib be used in combination with trametinib? Yes___ No___
- d. Will dabrafenib be used following progression following prior treatment options and no satisfactory alternative treatment options? Yes___ No___

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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Tafinlar[®] (dabrafenib) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****For Initial Authorization (continued):**

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

 Solid Tumor

- a. Is the diagnosis metastatic disease? Yes ___ No ___
- b. Does the member have a BRAF V600E mutation? Yes ___ No ___
- c. Does the member have colorectal cancer? Yes ___ No ___
- d. Has member progressed on prior therapies with no satisfactory treatment options? Yes ___ No ___
- e. Will dabrafenib be used in combination with trametinib? Yes ___ No ___

 Low-Grade Glioma (LGG)

- a. Does the member have a BRAF V600E mutation? Yes ___ No ___
- b. Will dabrafenib be used in combination with trametinib? Yes ___ No ___

 Other: _____**For Continued Authorization:**

- 1. Date of last dose: _____
- 2. Does the member have any evidence of progressive disease while on dabrafenib? Yes ___ No ___
- 3. Has member experienced any adverse drug reactions related to dabrafenib therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

Additional Information: _____

_____**(Page 2 of 2)****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:**

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