

Zelboraf[®] (vemurafenib) 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. Will vemurafenib be used as a single-agent? Yes ___ No ___

2. Please indicate the diagnosis and information:

 Melanoma

a. Is diagnosis unresectable or metastatic melanoma? Yes ___ No ___

b. Does member have BRAF V600E or V600K mutation? Yes ___ No ___

c. Does member have wild-type BRAF melanoma? Yes ___ No ___

d. Will vemurafenib be used in combination with cobimetinib, or in combination with cobimetinib and atezolizumab? Yes ___ No ___

e. Is vemurafenib being used as first-line therapy? Yes ___ No ___

f. Is vemurafenib being used as second-line or subsequent therapy? Yes ___ No ___

 Non-Small Cell Lung Cancer (NSCLC)

a. Is the disease 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 ___

 Hairy-Cell Leukemia

a. Is vemurafenib being used to treat disease progression following failure of purine analog therapy (i.e., pentostatin, cladribine)? Yes ___ No ___

b. Is member a candidate for purine analogs? Yes ___ No ___

i. If no, will vemurafenib be used in combination with rituximab or obinutuzumab?
Yes ___ No ___ **Erdheim-Chester Disease (ECD)**

a. Does member have BRAF V600E or V600K mutation? Yes ___ No ___

 Other: _____**(Page 1 of 2)****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**CONFIDENTIALITY 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.*



State of Oklahoma
SoonerCare

Zelboraf[®] (vemurafenib) Prior Authorization Form

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

Criteria

For Continued Authorization:

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

Additional Information: _____

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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.

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