

Mekinist[®] (trametinib) 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 BRAF V600E or V600K mutation? Yes ___ No ___

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

C. Will trametinib be used as a single-agent? Yes ___ No ___

D. Will trametinib be used in combination with dabrafenib? Yes ___ No ___

E. Will trametinib be used as first-line therapy? Yes ___ No ___

F. Will trametinib be used as second-line or subsequent therapy? Yes ___ No ___

i. If using as second-line or subsequent therapy, please indicate member's ECOG performance status (0-5): _____

G. Has member received prior BRAF inhibitor therapy (e.g., dabrafenib, vemurafenib)? Yes ___ No ___

i. If member has received prior BRAF inhibitor therapy, please indicate the following:

a. Was member intolerant to prior BRAF inhibitor therapy? Yes ___ No ___

b. Was there evidence of progression on prior BRAF inhibitor therapy? Yes ___ No ___

 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 trametinib be used in combination with dabrafenib? Yes ___ No ___

 Thyroid Cancer

A. Is the diagnosis locally advanced or metastatic disease? Yes ___ No ___

B. Does member have BRAF V600E mutation? Yes ___ No ___

C. Will trametinib be used in combination with dabrafenib? Yes ___ No ___

D. Will trametinib be used following progression following prior treatment options and no satisfactory alternative treatment options? Yes ___ No ___

(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.*

Mekinist[®] (trametinib) Prior Authorization Form

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

Criteria

For Initial Authorization, continued:

1. Please indicate the diagnosis and information, continued:

Serous Ovarian Cancer

A. Is diagnosis persistent or recurrent low-grade serous carcinoma? Yes ___ No ___

B. How will trametinib be used?

In combination with dabrafenib

i. As immediate treatment for serially rising CA-125 in members who previously received chemotherapy? Yes ___ No ___

ii. For disease progression on primary, maintenance, or recurrence therapy? Yes ___ No ___

iii. For stable or persistent disease (if not on maintenance therapy)? Yes ___ No ___

iv. For complete remission and relapse after completing chemotherapy? Yes ___ No ___

As a single agent for platinum-sensitive or platinum-resistant recurrence

Solid Tumor

A. Is the diagnosis metastatic disease? Yes ___ No ___

B. Does member have BRAF V600E mutation? Yes ___ No ___

C. Does member have colorectal cancer? Yes ___ No ___

D. Has member progressed on prior therapies with no satisfactory alternative treatment options?

Yes ___ No ___

E. Will trametinib be used in combination with dabrafenib? Yes ___ No ___

Low-Grade Glioma (LGG)

A. Does member have BRAF V600E mutation? Yes ___ No ___

B. Will trametinib be used in combination with dabrafenib? Yes ___ No ___

If diagnosis is not listed, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on trametinib? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to trametinib therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

(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:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
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