State of Oklahoma
SoonerCare

Braftovi® (Encorafenib) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

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

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

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ❑ **Unresectable or metastatic melanoma**
     - A. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
     - B. Will encorafenib be used in combination with binimetinib? Yes ☐ No ☐
   - ❑ **Advanced or metastatic colorectal cancer**
     - A. Does member have BRAF V600E mutation? Yes ☐ No ☐
     - B. Will encorafenib be used in combination with cetuximab or panitumumab? Yes ☐ No ☐
     - C. Has disease progressed following adjuvant therapy within the last 12 months? Yes ☐ No ☐
     - D. Has disease progressed following metastatic therapy? 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: _____

Additional Information: _____

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. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	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.*