State of Oklahoma
SoonerCare

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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:*** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

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

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

Criteria

Page 1 of 2–Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
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 (Tafinlar®)? 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 (Tafinlar®)? Yes☐ No☐

☐ **Anaplastic Thyroid Cancer (ATC)**
- 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 (Tafinlar®)? Yes☐ No☐
- D. Are there any satisfactory locoregional treatment options for the member? Yes☐ No☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® 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**.

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

Criteria

Page 2 of 2– Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

1. Please indicate the diagnosis and information, continued:

☐ **Serous Ovarian Cancer**
- A. Is diagnosis persistent or recurrent low-grade serous ovarian cancer? Yes☐ No☐
- B. Will trametinib be used as immediate treatment for serially rising CA-125 in members who previously received chemotherapy? Yes☐ No☐
- C. Will trametinib be used for disease progression on primary, maintenance, or recurrence therapy? Yes☐ No☐
- D. Will trametinib be used for stable or persistent disease (if member is not on maintenance therapy)? Yes☐ No☐
- E. Will trametinib be used for complete remission and relapse after completing chemotherapy? Yes☐ No☐

☐ **Solid Tumor**
- A. Is the diagnosis metastatic disease? Yes ☐ No ☐
- B. Does member have BRAF V600E mutation? Yes ☐ No ☐
- C. Has member progressed on prior therapies with no satisfactory alternative treatment options? Yes ☐ No ☐
- D. 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: _____

Additional Information: _____

_____

_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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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