State of Oklahoma
SoonerCare

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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:*** _____

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 all 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 dabrafenib be used as a single-agent? Yes ☐ No ☐
- D. Will dabrafenib be used in combination with trametinib (Mekinist®)? 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 using as second-line or subsequent therapy, 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 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 (Mekinist®)? 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 dabrafenib be used in combination with trametinib (Mekinist®)? Yes ☐ No ☐
- D. Are there any satisfactory locoregional treatment options for the member? Yes ☐ No ☐

☐ **Solid Tumor**
- A. Is the diagnosis metastatic disease? Yes ☐ No ☐
- B. Does the member have a BRAF V600E mutation? Yes ☐ No ☐
- C. Has member progressed on prior therapies with no satisfactory alternative treatment options? Yes ☐ No ☐
- D. Will dabrafenib be used in combination with trametinib? 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 availableat **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.

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

☐ **Low-Grade Glioma (LGG)**
   A. Does member have BRAF V600E mutation? Yes☐ No☐
   B. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes☐ No☐

☐ If diagnosis is not listed above, please indicate diagnosis: _____

For Initial Authorization, continued:

Additional Information: _____
_____
_____

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