Oncology Agents: BRAF Kinase Inhibitors – Oral

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. What is the patient's diagnosis?
   - ☐ Anaplastic thyroid cancer
   - ☐ Colorectal cancer, metastatic
   - ☐ Erdheim-Chester disease
   - ☐ Hairy cell leukemia, relapsed or refractory
   - ☐ Other Specify: _____
   - ☐ Solid tumor, unresectable or metastatic
   - ☐ Non-small cell lung cancer, metastatic
   - ☐ Melanoma adjuvant, unresectable, or metastatic
   - ☐ Low grade glioma

3. Provide the following for the patient:
   Indicate disease stage:
   Indicate disease type (i.e. New onset, refractory, etc.):
   Specify BRAF mutation

4. Indicate if prescribed by or in consultation with:
   ☐ Oncologist ☐ Hematologist ☐ Other Specify: _____

5. Will the requested medication be used in combination with any other oncolytic medication?
   ☐ Yes Specify: _____
   ☐ No

6. Has the patient progressed previously on a BRAF-inhibitor? ☐ Yes ☐ No

For diagnosis of Anaplastic Thyroid Cancer:

7. Is practitioner able to provide documentation of BRAF V600E mutation AND documentation that disease is locally advanced or metastatic with no locoregional treatment options? ☐ Yes ☐ No

8. Is the request for Dabrafenib (Tafinlar)? ☐ Yes ☐ No
   If yes, will Dabrafenib (Tafinlar) be used in combination with trametinib (mekinist)? ☐ Yes ☐ No

For diagnosis of Colorectal cancer, metastatic:

9. Will encorafenib (Braftovi) be used for first line treatment in combination with mFOLFOX6 (leucovorin, fluorouracil, and oxaliplatin) and cetuximab (Erbitux)? ☐ Yes ☐ No
10. Will encorafenib (Braftovi) be used as subsequent line treatment in combination with cetuximab (Erbitux)?

For diagnosis of Erdheim-Chester disease:

11. Will Vemurafenib (Zelboraf) be used in combination with any other medications for Erdheim-Chester disease? ☐ Yes ☐ No

For diagnosis of Hairy cell leukemia, relapsed or refractory:

12. Will Vemurafenib (Zelboraf) will be used with rituximab? ☐ Yes ☐ No

13. Has patient received therapy with a purine analog that was initiated less than two years prior to requesting vemurafenib (Zelboraf)? ☐ Yes ☐ No

For diagnosis of Low grade glioma:

14. For tovorafenib (Ojemda): Is the disease relapsed or refractory (i.e. disease has progressed on at least one prior systemic therapy?
15. For dabrafenib (Tafinlar): Will Tafinlar be used with trametinib (Mekinist) as first line systemic therapy?

For diagnosis of Melanoma adjuvant, unresectable, or metastatic:

16. Will dabrafenib (Tafinlar) be used in combination with trametinib (Mekinist) as adjuvant treatment (patient has undergone surgical resection)? ☐ Yes ☐ No

17. Has there been disease involvement in regional lymph nodes? ☐ Yes ☐ No

18. Will dabrafenib (Tafinlar) be used in combination with trametinib (Mekinist) as treatment for metastatic or unresectable melanoma? ☐ Yes ☐ No

19. Is the request for encorafenib (Braftovi)? ☐ Yes ☐ No
    If yes, will it be used in combination with binimetinib (Mektovi)? ☐ Yes ☐ No

20. Is the request for vemurafenib (Zelboraf)? ☐ Yes ☐ No
    If yes, will it be used in combination with cobimetinib (Cotellic) with or without atezolizumab (Tecentriq)? ☐ Yes ☐ No

For diagnosis of Non-small cell lung cancer, metastatic:

21. Is the request for encorafenib (Braftovi)? ☐ Yes ☐ No
    If yes, will it be used in combination with binimetinib (Mektovi)? ☐ Yes ☐ No

22. Is the request for Dabrafenib (Tafinlar)? ☐ Yes ☐ No
    If yes, will be used in combination with trametinib (Mekinist) ☐ Yes ☐ No

For diagnosis of Solid tumor, unresectable or metastatic:

23. Please indicate the following for the patient (Select all that apply):
    ☐ Biliary tract cancer

☐ High grade glioma
☐ Low grade serous ovarian cancer
☐ Adenocarcinoma of the small intestine

24. Indicate for patient:
    Height (cm): **Date taken:**
    Weight (kg): **Date taken:**
    Body surface area (m^2): **Date taken:**

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)