SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Tafinlar® (Dabrafenib) 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: _____ ***Provider 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 as detected by an FDA-approved test? 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. Is dabrafenib being used as first-line therapy? Yes☐ No☐
     - F. Is dabrafenib being used as second-line or subsequent therapy? Yes☐ No☐
       - i. If being used 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 as detected by an FDA-approved test? 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 as detected by an FDA-approved test? 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☐
   - ☐ If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Does patient have any evidence of progressive disease while on dabrafenib? Yes☐ No☐
2. Has the member experienced any adverse drug reactions related to dabrafenib therapy? Yes☐ No☐
   If yes, please specify adverse reactions: _____

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.

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