

State of Oklahoma
Oklahoma Health Care Authority
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

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber 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? 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 ___

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

For Continued Authorization:

- 1. Date of last dose: _____
- 2. Does patient 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: _____

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

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