

State of Oklahoma
Oklahoma Health Care Authority
Zelboraf® (Vemurafenib) 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: _____ Prescriber Name: _____
Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

- Will vemurafenib be used as a single-agent? Yes ___ No ___
- Please indicate the diagnosis and information:
 - Unresectable or Metastatic Melanoma
 - Does member have BRAF V600E or V600K mutation as detected by an FDA-approved test? Yes ___ No ___
 - Does member have wild-type BRAF melanoma? Yes ___ No ___
 - Will vemurafenib be used in combination with cobimetinib? Yes ___ No ___
 - Is vemurafenib being used as first-line therapy? Yes ___ No ___
 - Is vemurafenib being used as second-line or subsequent therapy? Yes ___ No ___
 - If being used as second-line or subsequent therapy, please provide member's ECOG performance status (0-5): _____
 - Non-Small Cell Lung Cancer (NSCLC)
 - Is the diagnosis refractory or metastatic disease? Yes ___ No ___
 - Does member have BRAF V600E or V600K mutation as detected by an FDA-approved test? Yes ___ No ___
 - Does member have wild-type BRAF NSCLC? Yes ___ No ___
 - Hairy-Cell Leukemia
 - Is vemurafenib being used to treat disease progression following failure of purine analog therapy (e.g., pentostatin, cladribine)? Yes ___ No ___
 - If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

- Does patient have any evidence of progressive disease while on vemurafenib? Yes ___ No ___
 - Has the member experienced any adverse drug reactions related to vemurafenib therapy? Yes ___ No ___
If yes, please specify adverse reactions: _____
- Additional Information: _____

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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