SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Mekinist® (Trametinib) 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):

1. Please indicate the diagnosis and information:
   - ☐ Unresectable or metastatic melanoma
     - A. Does member have BRAF V600E or V600K mutation as detected by FDA-approved test? Yes____ No____
     - B. Does member have wild-type BRAF melanoma? Yes____ No____
     - C. Will trametinib be used as a single-agent? Yes____ No____
     - D. Will trametinib be used in combination with dabrafenib? Yes____ No____
     - E. Will trametinib be used as first-line therapy? Yes____ No____
     - F. Will trametinib be used as second-line or subsequent therapy? Yes____ No____
       - i. If using as second-line or subsequent therapy, please indicate member's ECOG performance status (0-5): _____
     - G. Has member received prior BRAF inhibitor therapy (e.g., dabrafenib, vemurafenib)? Yes___ No___
       - i. If member has received prior BRAF inhibitor therapy, please indicate the following:
         - a. Was member intolerant to prior BRAF inhibitor therapy? Yes____ No____
         - b. Was there evidence of progression on prior BRAF inhibitor therapy? Yes___ No___
   - ☐ 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 trametinib be used in combination with dabrafenib? Yes____ No____
   - ☐ If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on trametinib? Yes____ No____
2. Has the member experienced any adverse drug reactions related to trametinib 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