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:_____) *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 trametinib be used as a single-agent? Yes☐ No☐
     - D. Will trametinib be used in combination with dabrafenib (Tafinlar®)? 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? Yes☐ No☐
     - C. Does member have wild-type BRAF NSCLC? Yes☐ No☐
     - D. Will trametinib be used in combination with dabrafenib (Tafinlar®)? 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 trametinib be used in combination with dabrafenib (Tafinlar®)? 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. Daste of last dose:_____
2. Does member have any evidence of progressive disease while on trametinib? Yes☐ No☐
3. 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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*