OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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

Page 1 of 2– Please complete and return all pages. Failure to complete all pages will result in processing delays.
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____
   - ☐ **Serous Ovarian Cancer**
     - A. Is diagnosis persistent or recurrent low-grade serous ovarian cancer? Yes____ No____
     - B. Will trametinib be used as immediate treatment for serially rising CA-125 in members who previously received chemotherapy? Yes____ No____
     - C. Will trametinib be used for disease progression on primary, maintenance, or recurrence therapy? Yes____ No____
     - D. Will trametinib be used for stable or persistent disease (if member is not on maintenance therapy)? Yes____ No____
     - E. Will trametinib be used for complete remission and relapse <6 months after completing chemotherapy? Yes____ No____
     - F. Will trametinib be used for radiographic and/or clinical relapse in members with previous complete remission and relapse ≥6 months after completing prior chemotherapy? Yes____ No____

DRAFT

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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Mekinist® (Trametinib) Prior Authorization Form

***Member Name:*_____ *Date of Birth:*_____ *Member ID#:*_____**

Criteria

Page 2 of 2– Please complete and return all pages. Failure to complete all pages will result in processing delays.
For Initial Authorization, continued:

1. Please indicate the diagnosis and information, continued:

❑ **If diagnosis is not listed, please indicate diagnosis:**_____

Additional Information: _____
_____
_____

For Continued Authorization:

1. Date 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:*_____

Additional Information:_____
_____
_____

DRAFT

Pescriber 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.*

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.*