

State of Oklahoma
Oklahoma Health Care Authority
Zelboraf® (Vemurafenib) 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. Will vemurafenib be used as a single-agent? Yes ___ No ___
2. Please indicate the diagnosis and information:
 - Melanoma**
 - A. Is diagnosis unresectable or metastatic melanoma? Yes ___ No ___
 - B. Does member have BRAF V600E or V600K mutation? Yes ___ No ___
 - C. Does member have wild-type BRAF melanoma? Yes ___ No ___
 - D. Will vemurafenib be used in combination with cobimetinib? Yes ___ No ___
 - E. Is vemurafenib being used as first-line therapy? Yes ___ No ___
 - F. Is vemurafenib being used as second-line or subsequent therapy? Yes ___ No ___
 - i. If being used as second-line or subsequent therapy, please provide member's ECOG performance status: _____
 - 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 ___
 - Hairy-Cell Leukemia**
 - A. Is vemurafenib being used to treat disease progression following failure of purine analog therapy (i.e., pentostatin, cladribine)? Yes ___ No ___
 - Erdheim-Chester Disease (ECD)**
 - A. Does member have BRAF V600E or V600K mutation? Yes ___ No ___
 - If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on vemurafenib? Yes ___ No ___
3. 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.

<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>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.</i></p>
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