PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Mekinist (trametinib)

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Indicate whether the patient is a new start to Mekinist or whether this is continuation of established therapy.

☐ CONTINUATION of Mekinist therapy
☐ NEW START to Mekinist

Q2. For what diagnosis is the drug being prescribed (pick one)?

☐ Malignant melanoma, unresectable or metastatic
☐ Other

Q3. Please provide ICD code(s) for diagnosis

Q4. Is prescribing physician an oncology specialist?

☐ Yes ☐ No

Q5. Has the presence of BRAF V600E or V600K mutation been confirmed by testing?

☐ Yes ☐ No

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Q6. Has the patient received prior BRAF-inhibitor therapy?

☐ Yes (describe treatment history)

☐ No

Q7. Will Mekinist be used in combination with Tafinlar? (If yes, please fill out a separate prior authoirization form for Tafinlar).

☐ Yes ☐ No

Q8. Additional comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function