

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:	
Member/Subscriber Number:	Supervising Physician:	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	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. <input type="checkbox"/> CONTINUATION of Mekinist therapy <input type="checkbox"/> NEW START to Mekinist
Q2. For what diagnosis is the drug being prescribed (pick one)? <input type="checkbox"/> Malignant melanoma, unresectable or metastatic <input type="checkbox"/> Other
Q3. Please provide ICD code(s) for diagnosis
Q4. Is prescribing physician an oncology specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Has the presence of BRAF V600E or V600K mutation been confirmed by testing? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Patient Name:	Prescriber Name: Supervising Physician:
Q6. Has the patient received prior BRAF-inhibitor therapy? <input type="checkbox"/> Yes (describe treatment history) <input type="checkbox"/> No	
Q7. Will Mekinist be used in combination with Tafinlar? (If yes, please fill out a separate prior authorization form for Tafinlar). <input type="checkbox"/> Yes <input type="checkbox"/> 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

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