PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Zelboraf

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. Is the patient a NEW START to Zelboraf therapy?

☐ Yes

☐ No (describe Zelboraf treatment history)

Q2. What diagnosis is this drug being prescribed for?

☐ Unresectable or metastatic melanoma

☐ Other (please specify)

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2B or higher recommendation per NCCN compendia or guidelines.

Q4. Please provide ICD code(s) for diagnosis

Q5. Does this patient have a BRAF V600E mutation?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

Q6. 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