Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

Cotellic

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: ________________________________, NPI#: ___________________________
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Cutaneous melanoma
   ❑ Glioma
   ❑ Meningioma
   ❑ Astrocytoma
   ❑ Other ____
2. What is the ICD-10 code? _________________
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. What is the patient's BRAF V600 mutation status (e.g., BRAF V600E or V600K)? ***ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.***
   ❑ Positive ❑ Negative ❑ Unknown or not available

Complete the following section if the patient's diagnosis is cutaneous melanoma.

6. In which of the following settings will the requested medication be used?
   ❑ Unresectable or metastatic disease, *skip to #12*
   ❑ Adjuvant treatment
   ❑ Other ____
7. Does the patient have stage III disease? ❑ Yes ❑ No
8. Has the patient had a complete resection? *If Yes, skip to #10* ❑ Yes ❑ No
9. Does the patient have evidence of disease? ❑ Yes ❑ No
10. Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist)? ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

11. Will the requested medication be used in combination with vemurafenib (Zelboraf)?
❑ Yes ❑ No *No further questions*

12. In what regimen will the requested medication be used?
❑ In combination with vemurafenib (Zelboraf) only
❑ In combination with vemurafenib (Zelboraf and atezolizumab (Tecentriq)
❑ Other ____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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