

Mekinist (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-866-249-6155

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.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

1. What is the patient's diagnosis?
 Melanoma
 Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? Yes No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
 Yes No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? Yes No *Continue to #6 and complete this form in its entirety.*
6. Is the disease unresectable or metastatic? Yes No
7. Has genetic testing been performed for the BRAF V600E or V600K mutation? Yes No
ACTION REQUIRED: Attach test results
8. What was the member's BRAF mutation test result? Positive Negative
9. Will Mekinist be used in combination with Tafenlar (dabrafenib)? *If Yes, no further questions.* Yes No
10. Will Mekinist be used as a single agent? Yes No
11. Is the member's anticipated clinical deterioration less than or equal to 12 weeks? Yes No
12. Has the member experienced intolerance to previous BRAF-inhibitor therapy (eg, vemurafenib [Zelboraf], dabrafenib [Tafenlar])? Yes No

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)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Mekinist CF - 2/2016.

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