OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare

Zelboraf® (vemurafenib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy Billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Pharmacy Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Will vemurafenib be used as a single-agent? Yes ☐ No ☐
2. Please indicate the diagnosis and information:
   - ☐ **Melanoma**
     a. Is diagnosis unresectable or metastatic melanoma? Yes ☐ No ☐
     b. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
     c. Does member have wild-type BRAF melanoma? Yes ☐ No ☐
     d. Will vemurafenib be used in combination with cobimetinib? Yes ☐ No ☐
     e. Is vemurafenib being used as first-line therapy? Yes ☐ No ☐
     f. Is vemurafenib being used as second-line or subsequent therapy? Yes ☐ No ☐
        i. If being used as second-line or subsequent therapy, please provide member's ECOG performance status: _____
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     a. Is the disease refractory or metastatic disease? Yes ☐ No ☐
     b. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
     c. Does member have wild-type BRAF NSCLC? Yes ☐ No ☐
   - ☐ **Hairy-Cell Leukemia**
     a. Is vemurafenib being used to treat disease progression following failure of purine analog therapy (i.e., pentostatin, cladribine)? Yes ☐ No ☐
     b. Is member a candidate for purine analogs? Yes ☐ No ☐
        i. If no, will vemurafenib be used in combination with rituximab or obinutuzumab? Yes ☐ No ☐
   - ☐ **Erdheim-Chester Disease (ECD)**
     a. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
   - ☐ **Other:** _____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Criteria

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on avapritinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to avapritinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

_____

Additional Information:_____

_____

_____

_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

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