Prior Authorization Request Form for
encorafenib (**Braftovi**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question **3**	☐ No Proceed to question **7**
3. Does the patient have BRAF V600E or BRA FV600K mutation confirmed by an FDA-approved test?	☐ Yes Proceed to question **4**	☐ No Proceed to question **7**
4. Will Braftovi be taken in combination with Mektovi?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Is the patient on dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), or cobimetinib (Cotellic) concurrently?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **6**
6. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Prior Authorization Request Form for
encorafenib (**Braftovi**)

7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 August 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: