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

JOHNS HOPKINS
HEALTH PLANS
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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.

Prior authorization does not expire.

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. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. For which indication is the requested medication being prescribed?	☐ unresectable or metastatic melanoma - Proceed to question **4** ☐ unresectable or metastatic colorectal cancer - Proceed to question **5** ☐ Metastatic non-small cell lung cancer - Proceed to question **6** ☐ Other - Proceed to question **15**	
4. Does the patient have BRAF V600E or BRAF V600K mutation confirmed by an FDA-approved test?	☐ Yes Proceed to question **7**	☐ No Proceed to question **15**
5. Does the patient have BRAF V600E mutation confirmed by an FDA-approved test?	☐ Yes Proceed to question **8**	☐ No Proceed to question **15**
6. Does the patient have BRAF V600E mutation confirmed by an FDA-approved test?	☐ Yes Proceed to question **7**	☐ No Proceed to question **15**

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7. Will Braftovi be taken in combination with binimetinib (Mektovi)?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
8. Will Braftovi be taken in combination with either cetuximab (Erbitux) or panitumumab (Vectibix)?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Is the patient on dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), or cobimetinib (Cotellic) concurrently?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **10**
10. What is the patient's age/gender?	☐ Male - proceed to question **14** ☐ Female of childbearing age - proceed to question **11** ☐ Female not of childbearing age - **Sign and date below**	
11. Will the patient take highly effective contraception while taking the requested medication and for 2 weeks after the last dose?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **13**
13. Will the patient avoid breastfeeding during treatment or within two weeks after the cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
14. Is the patient aware that there is an increased chance of male infertility if the requested medication becomes supratherapeutic?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
15.Is the patient on dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), or cobimetinib (Cotellic) concurrently?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **16**
16. What is the patient's age/gender?	☐ Male - proceed to question **20** ☐ Female of childbearing age - proceed to question **17** ☐ Female not of childbearing age - proceed to question **21**	
17. Will the patient take highly effective contraception while taking the requested medication and for 2 weeks after the last dose?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved

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18. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **19**
19. Will the patient avoid breastfeeding during treatment or within two weeks after the cessation of treatment?	☐ Yes proceed to question **21**	☐ No **STOP** Coverage not approved
20. Is the patient aware that there is an increased chance of male infertility if the requested medication becomes supratherapeutic?	☐ Yes proceed to question **21**	☐ No **STOP** Coverage not approved
21. Please provide the diagnosis.	_____ Proceed to question **22**	
22. 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

[26 June 2024]

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