Prior Authorization Request Form for
cobimetinib (**Cotellic**)

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

USFHP Pharmacy Prior Authorization Form

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

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 metastatic melanoma?	☐ Yes Proceed to question 3	☐ No Proceed to question 7
3. Does the patient have BRAF V600E or V600K mutation confirmed by an FDA-approved test?	☐ Yes Proceed to question 4	☐ No Proceed to question 7
4. Will Cotellic be used in combination with vemurafenib (Zelboraf)?	☐ Yes Proceed to question 5	☐ No Proceed to question 7
5. Is the patient on encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), or trametinib (Mekinist) 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

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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: