TRICARE Prior Authorization Request Form for
dabrafenib **(Tafinlar)**

JOHNS HOPKINS
HEALTH PLANS
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.

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. Will Tafinlar be used in combination with Mekinist (trametinib)?	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. For which indication is Tafinlar being prescribed?	☐ Melanoma - **Proceed to question 3** ☐ Metastatic Non-small Cell Lung cancer – **Proceed to question 7** ☐ Locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options - **Proceed to question 7** ☐ Solid tumor, unresectable or metastatic, with progression following prior treatment and no satisfactory alternative treatment options - **Proceed to question 5** ☐ Low-grade glioma (LGG) requiring systemic therapy - **Proceed to question 6** ☐ Other - **Proceed to question 9**	
3. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question **4**	☐ No Proceed to question **9**
4. Does the patient have a BRAF-V600E or BRAF-V600K mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**
5. Is the patient greater than or equal to 1 year of age?	☐ Yes Proceed to question **7**	☐ No Proceed to question **9**

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6. How old is the patient?	☐ Less than 1 year of age - Proceed to question **9** ☐ 1 year of age or older but less than 18 years of age - Proceed to question **7** ☐ Greater than 18 years of age - Proceed to question **9**	
7. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test (if one is available for this indication)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**
8. Is the patient taking encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), or cobimetinib (Cotellic)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**
9. Please provide the diagnosis.	_____ Proceed to question **10**	
10. 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

[03 January 2024]

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