Prior Authorization Request Form for Zelboraf (vemurafenib)

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:**

Question		
1. Does the patient have a documented diagnosis of Erdheim-Chester Disease with BRAF V600 mutation?	☐ Yes Proceed to Question **3**	☐ No Proceed to Question **2**
2. Does the patient have a documented diagnosis of unresectable or metastatic melanoma with BRAF^{V600E} mutation that has been detected by an FDA-approved test such as Cobas 4800?	☐ Yes Proceed to Question **3**	☐ No Proceed to Question **4**
3. Will the patient be taking the requested medication concurrently with encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), or trametinib (Mekinist)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
4. Please provide the diagnosis.	______________________ Proceed to question **5**	
5. 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

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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: