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

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. 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 5** ☐ Locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options - **Proceed to question 5** ☐ Other **- Proceed to question 7**	
3. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question **4**	☐ No Proceed to question **7**
4. Does the patient have a BRAF-V600E or BRAF-V600K mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**
5. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**

Continue on next page

6. Is the patient taking encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), or cobimetinib (Cotellic)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**
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: