

US Family Health Plan Prior Authorization Request Form for encorafenib (**Braftovi**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have unresectable or metastatic melanoma?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 7
3. Does the patient have BRAF V600E or BRA FV600K mutation confirmed by an FDA-approved test?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 7
4. Will Braftovi be taken in combination with Mektovi?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 7
5. Is the patient on dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), or cobimetinib (Cotellic) concurrently?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 6
6. Is the requested medication being prescribed by or in consultation with an oncologist?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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 I certify the above is true to the best of my knowledge. Please sign and date:

3

Prescriber Signature

Date

[14 August 2019]