US Family Health Plan
Prior Authorization Request Form for
trametinib **(Mekinist)**

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 **617-562-5296**

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. Will Mekinist be used in combination with Tafinlar (dabrafenib)?	☐ Yes Proceed to question 2	☐ No Proceed to question 3
2. For which indication is Mekinist being prescribed?	☐ Melanoma **Proceed to 4** ☐ Metastatic Non-small Cell Lung cancer – **Proceed to 6** ☐ Locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options - **Proceed to question 6** ☐ Other **- STOP** Coverage not approved	
3. Has the patient received prior BRAF-inhibitor therapy, for example, with Tafinlar or Zelboraf?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 4
4. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Does the patient have a BRAF-V600E or BRAF-V600K mutation as detected by an FDA-approved test?	☐ Yes Proceed to question 7	☐ No **STOP** Coverage not approved
6. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test?	☐ Yes Proceed to question 7	☐ No **STOP** Coverage not approved

Prior Authorization Request Form for
trametinib **(Mekinist)**

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

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[28 November 2018]