US Family Health Plan
Prior Authorization Request Form for
dabrafenib **(Tafinlar)**

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:

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 **- STOP** Coverage not approved	
3. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
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 **STOP** Coverage not approved
5. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved

Continue on next page

	6. Is the patient taking encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), or cobimetinib (Cotellic)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 10

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

_______________________________ _______________
Prescriber Signature Date

[28 November 2018]