US Family Health Plan
Prior Authorization Request Form for
Zelboraf **(vemurafenib)**

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. 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 **STOP** **Coverage not approved**
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**

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

Prescriber Signature _____ Date _____

[28 November 2018]