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 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**

Prior Authorization does not expire.

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 question **8** ☐ Locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options - Proceed to question **8** ☐ Low-grade glioma (LGG) requiring systemic therapy - Proceed to question **7** ☐ Solid tumor, unresectable or metastatic, with progression following prior treatment and no satisfactory alternative treatment options **-** Proceed to question **6** ☐ Other **-** Proceed to question **10**	
3. Has the patient received prior BRAF-inhibitor therapy, for example, with Tafinlar or Zelboraf?	☐ Yes Proceed to question **10**	☐ No Proceed to question **4**
4. Does the patient have unresectable or metastatic melanoma?	☐ Yes Proceed to question **5**	☐ No Proceed to question **10**
5. Does the patient have a BRAF-V600E or BRAF-V600K mutation as detected by an FDA-approved test?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**

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6. Is the patient greater than or equal to 1 year of age?	☐ Yes Proceed to question **8**	☐ No Proceed to question **10**
7. How old is the patient?	☐ Less than 1 year of age - Proceed to question **10** ☐ 1 year of age or older but less than 18 years of age - Proceed to question **8** ☐ Greater than 18 years of age - Proceed to question **10**	
8. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test (if one is available for this indication)?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Is the patient taking encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), or cobimetinib (Cotellic)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**
10. Please provide the diagnosis.	_____ Proceed to question **11**	
11. 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

[03 January 2024]