

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior Authorization does not expire. Clinical documentation may be required.

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 requested medication prescribed by or in consultation with a hematologist/oncologist?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Will Mekinist be used in combination with Tafenlar (dabrafenib)?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 4
3. For which indication is Mekinist being prescribed?	<div style="padding: 5px;"><input type="checkbox"/> Melanoma – Proceed to 6</div> <div style="padding: 5px;"><input type="checkbox"/> Adjuvant treatment of patients of melanoma with involvement of lymph node(s), following complete resection - Proceed to 6</div> <div style="padding: 5px;"><input type="checkbox"/> Metastatic Non-small Cell Lung cancer – Proceed to question 7</div> <div style="padding: 5px;"><input type="checkbox"/> Locally advanced or metastatic anaplastic thyroid cancer without satisfactory locoregional treatment options - Proceed to question 7</div> <div style="padding: 5px;"><input type="checkbox"/> Low-grade glioma (LGG) requiring systemic therapy - Proceed to question 7</div> <div style="padding: 5px;"><input type="checkbox"/> Solid tumor, unresectable or metastatic, with progression following prior treatment and no satisfactory alternative treatment options - Proceed to question 7</div> <div style="padding: 5px;"><input type="checkbox"/> Other - Proceed to question 9</div>	
4. Has the patient received prior BRAF-inhibitor therapy, for example, with Tafenlar or Zelboraf?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 5

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<p>5. Does the patient have unresectable or metastatic melanoma?</p>	<p><input type="checkbox"/> Yes Proceed to question 6</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>6. Does the patient have a BRAF-V600E or BRAF-V600K mutation as detected by an FDA-approved test?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>7. Does the patient have a BRAF-V600E mutation as detected by an FDA-approved test (if one is available for this indication)?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>8. Is the patient taking encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), or cobimetinib (Cotellic)?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>
<p>9. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation.</p> <p>To facilitate approval, please list the diagnosis, guideline version, and page number:</p>	<div style="border-top: 1px solid black; height: 40px; margin-bottom: 10px;"></div> <p style="text-align: center;">Sign and date below</p>	

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

Date _____

[08 January 2025]