



**Braftovi (encorafenib)**  
**Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE  FEMALE HEIGHT (IN/CM): \_\_\_\_\_ WEIGHT (LB/KG): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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**1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?**  YES (if yes, complete below)  NO

<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
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**2. LIST DIAGNOSES:** **ICD-10:**

<input type="checkbox"/> Locally advanced melanoma <input type="checkbox"/> Unresectable melanoma <input type="checkbox"/> Metastatic melanoma <input type="checkbox"/> Metastatic colorectal cancer <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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**3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.**

**Clinical Information:**

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial?  Yes  No

**For Melanoma diagnoses, answer the following:**

Does patient have a BRAF V<sub>600E</sub> mutation?  Yes  No *Please submit chart documentation.*

Does patient have a BRAF V<sub>600K</sub> mutation?  Yes  No *Please submit chart documentation.*

Does patient have both BRAF V<sub>600E</sub> and a BRAF V<sub>600K</sub> mutation?  Yes  No *Please submit chart documentation.*

Is patient's tumor Stage IIIB, IIIC, or IV?  Yes  No *Please submit chart documentation.*

Has patient been previously treated for their melanoma?  Yes  No *Please submit chart documentation.*

Has patient failed on only one previous first-line immunotherapy?  Yes  No *Please submit chart documentation.*

Has patient been previously treated with a BRAF inhibitor?  Yes  No *Please submit chart documentation.*

Has patient been previously treated with a MEK inhibitor?  Yes  No *Please submit chart documentation.*

Has patient been previously treated with a systemic chemotherapy?  Yes  No *Please submit chart documentation.*

Will patient be treated with Mekovi in combination with Braftovi?  Yes  No

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**For Metastatic colorectal diagnosis, answer the following:**

Does patient have a BRAF V<sub>600E</sub> mutation?  Yes  No *Please submit chart documentation.*

Has patient progressed after only one and no more than two previous treatment regimens?  Yes  No  
*Please submit chart documentation.*

Has patient been previously treated with a BRAF inhibitor?  Yes  No *Please submit chart documentation.*

Has patient been previously treated with a MEK inhibitor?  Yes  No *Please submit chart documentation.*

Has patient been previously treated with an EGFR inhibitor?  Yes  No *Please submit chart documentation.*

Will Braftovi will be used in combination with the EGFR inhibitor Erbitux® (cetuximab)?  Yes  No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

