



Please complete ALL information below and fax your request to 1-888-671-5285

Mekinist® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Anaplastic thyroid cancer (ATC)

Melanoma

Non-small cell lung cancer

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Will Mekinist be used in combination with Tafinlar (dabrafenib)? Yes No

Is Mekinist prescribed by or in consultation with an oncologist? Yes No

Select if the cancer has the following mutation type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA):

BRAF V600E BRAF V600K

For anaplastic thyroid cancer (ATC), also answer the following:

Does the patient have locally advanced or metastatic disease? Yes No

Can the cancer be treated with standard locoregional treatment options? Yes No

For melanoma, also answer the following:

Does the patient have metastatic or unresectable disease? Yes No

Is Mekinist being used as adjuvant treatment for melanoma? Yes No

Does the patient have involvement of lymph nodes following complete resection? Yes No

For non-small cell lung cancer, also answer the following:

Does the patient have metastatic disease? Yes No

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Mekinist therapy? 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: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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