FUTURE SCRIPTS

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

Tafinlar® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Anaplastic thyroid cancer (ATC)
❑ Melanoma
❑ Metastatic non-small cell lung cancer
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

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

❑ BRAFV600E ❑ BRAFV600K

Is Tafinlar used in combination with Mekinist (trametinib)? ❑ **Yes** ❑ **No**

Is Tafinlar prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

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

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

Is the cancer treatable with standard locoregional treatment options? ❑ **Yes** ❑ **No**

For melanoma, also answer the following:

Does the patient have unresectable or metastatic melanoma? ❑ **Yes** ❑ **No**

Will Tafinlar be used as adjunctive therapy? ❑ **Yes** ❑ **No**

Is there involvement of lymph nodes following complete resection? ❑ **Yes** ❑ **No**

Reauthorization:

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

Does the patient show evidence of progressive disease while on Tafinlar 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?

_____

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Please note: This request may be denied unless all required information is received.