OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Mekinist® (Trametinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____**)** ***Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

Page 1 of 2– Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.
For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

☐ **Unresectable or Metastatic Melanoma**
- A. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
- B. Does member have wild-type BRAF melanoma? Yes ☐ No ☐
- C. Will trametinib be used as a single-agent? Yes ☐ No ☐
- D. Will trametinib be used in combination with dabrafenib (Tafinlar®)? Yes ☐ No ☐
- E. Will trametinib be used as first-line therapy? Yes ☐ No ☐
- F. Will trametinib be used as second-line or subsequent therapy? Yes ☐ No ☐
  - i. If using as second-line or subsequent therapy, please indicate member's ECOG performance status (0-5): _____
- G. Has member received prior BRAF inhibitor therapy (e.g., dabrafenib, vemurafenib)? Yes ☐ No ☐
  - i. If member has received prior BRAF inhibitor therapy, please indicate the following:
    - a. Was member intolerant to prior BRAF inhibitor therapy? Yes ☐ No ☐
    - b. Was there evidence of progression on prior BRAF inhibitor therapy? Yes ☐ No ☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is the diagnosis refractory or metastatic disease? Yes ☐ No ☐
- B. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
- C. Does member have wild-type BRAF NSCLC? Yes ☐ No ☐
- D. Will trametinib be used in combination with dabrafenib (Tafinlar®)? Yes ☐ No ☐

☐ **Anaplastic Thyroid Cancer (ATC)**
- A. Is the diagnosis locally advanced or metastatic disease? Yes ☐ No ☐
- B. Does member have BRAF V600E mutation? Yes ☐ No ☐
- C. Will trametinib be used in combination with dabrafenib (Tafinlar®)? Yes ☐ No ☐
- D. Are there any satisfactory locoregional treatment options for the member? Yes ☐ No ☐

☐ **Serous Ovarian Cancer**
- A. Is diagnosis persistent or recurrent low-grade serous ovarian cancer? Yes ☐ No ☐
- B. Will trametinib be used as immediate treatment for serially rising CA-125 in members who previously received chemotherapy? Yes ☐ No ☐
- C. Will trametinib be used for disease progression on primary, maintenance, or recurrence therapy? Yes ☐ No ☐
- D. Will trametinib be used for stable or persistent disease (if member is not on maintenance therapy)? Yes ☐ No ☐
- E. Will trametinib be used for complete remission and relapse <6 months after completing chemotherapy? Yes ☐ No ☐
- F. Will trametinib be used for radiographic and/or clinical relapse in members with previous complete remission and relapse ≥6 months after completing prior chemotherapy? Yes ☐ No ☐

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

State of Oklahoma
SoonerCare

Mekinist® (Trametinib) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Criteria

Page 2 of 2– Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

1. Please indicate the diagnosis and information, continued:

❑ **If diagnosis is not listed, please indicate diagnosis:**_____

Additional Information: _____
_____
_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on trametinib? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to trametinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____
_____
_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Pescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*