

**State of Oklahoma  
Oklahoma Health Care Authority  
Tafinlar® (Dabrafenib) 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**

**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 dabrafenib be used as a single-agent? Yes \_\_\_ No \_\_\_
- D. Will dabrafenib be used in combination with trametinib (Mekinist®)? Yes \_\_\_ No \_\_\_
- E. Will dabrafenib be used as first-line therapy? Yes \_\_\_ No \_\_\_
- F. Will dabrafenib be used as second-line or subsequent therapy? Yes \_\_\_ No \_\_\_
  - i. If using as second-line or subsequent therapy, please provide member's ECOG performance status (0-5): \_\_\_\_\_

**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 dabrafenib be used as a single-agent? Yes \_\_\_ No \_\_\_
- E. Will dabrafenib be used in combination with trametinib (Mekinist®)? 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 dabrafenib be used in combination with trametinib (Mekinist®)? Yes \_\_\_ No \_\_\_
- D. Are there any satisfactory locoregional treatment options for the member? Yes \_\_\_ No \_\_\_

If diagnosis is not listed above, please indicate diagnosis: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Does patient have any evidence of progressive disease while on dabrafenib? Yes \_\_\_ No \_\_\_
3. Has the member experienced any adverse drug reactions related to dabrafenib therapy? Yes \_\_\_ No \_\_\_  
If yes, please specify adverse reactions: \_\_\_\_\_

**Prescriber 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. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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