

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

### Drug Information

**Pharmacy billing (NDC:** \_\_\_\_\_ **)**

**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

### 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:

1. Please indicate the diagnosis and information:

☐ **Unresectable or Metastatic Melanoma**

- A. Does member have BRAF V600E or V600K mutation? Yes \_\_\_\_\_ No \_\_\_\_\_  
B. Will binimetinib be used in combination with encorafenib? Yes \_\_\_\_\_ No \_\_\_\_\_

☐ **Non-Small Cell Lung Cancer (NSCLC)**

- A. Is diagnosis metastatic NSCLC? Yes \_\_\_\_\_ No \_\_\_\_\_  
B. Does member have BRAF V600E mutation? Yes \_\_\_\_\_ No \_\_\_\_\_  
C. Will binimetinib be used in combination with encorafenib? Yes \_\_\_\_\_ No \_\_\_\_\_

☐ If answer is none of the above, please indicate diagnosis: \_\_\_\_\_

Additional Information: \_\_\_\_\_

#### For Continued Authorization:

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

Additional Information: \_\_\_\_\_

**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.**

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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