

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 (Initial approval will be for the duration of 6 months):

1. Diagnosis of unresectable or metastatic melanoma? Yes ___ No ___
 - A. If answer is 'yes' to question 1, please check all of the following that apply:
 - BRAF V600E or V600K mutation detected by an FDA-approved test
 - Wild-type BRAF melanoma
 - Used as first-line therapy in combination with vemurafenib
 - Used as second-line therapy or subsequent therapy with vemurafenib
 - i. If cobimetinib is being used as second-line therapy or subsequent therapy, please provide member's ECOG performance status (0-5): _____
2. If answer is 'no' to question 1, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on cobimetinib? Yes ___ No ___
2. Has member experienced any adverse drug reactions related to cobimetinib 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. 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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