Prescriber Criteria Form Zelboraf 2024 PA Fax 696-A v2 010124.docx Zelboraf (vemurafenib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zelboraf (vemurafenib).

Drug Name: Zelboraf (vemurafenib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of melanoma? [If no, then skip to question 6.]	Yes	No
2	Will the requested medication be used for the adjuvant treatment of melanoma? [If yes, then skip to question 4.]	Yes	No
3	Is the melanoma unresectable, limited resectable, or metastatic? [If no, then no further questions.]	Yes	No
4	Is the tumor positive for BRAF V600 activating mutation (e.g., V600E or V600K)? [If no, then no further questions.]	Yes	No
5	Will the requested drug be used as a single agent or in combination with cobimetinib? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of central nervous system (CNS) cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma)? [If no, then skip to question 10.]	Yes	No
7	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes	No

8	Is the requested drug being used for the treatment of pediatric diffuse high-grade glioma? [If yes, then no further questions.]	Yes	No
9	Will the requested drug be used in combination with cobimetinib? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of Erdheim-Chester Disease (ECD) or Langerhans Cell Histiocytosis? [If no, then skip to question 12.]	Yes	No
11	Is the disease positive for a BRAF V600 mutation? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 15.]	Yes	No
13	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes	No
14	Is the tumor positive for a BRAF V600E mutation? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of hairy cell leukemia? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of papillary, follicular, or Hurthle cell thyroid carcinoma? [If no, then no further questions.]	Yes	No
17	Is the disease amenable to radioactive iodine (RAI) therapy? [If yes, then no further questions.]	Yes	No
18	Is the tumor positive for a BRAF mutation?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____