Prescriber Criteria Form Tafinlar 2024 PA Fax 1000-A v2 010124.docx Tafinlar (dabrafenib) 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 Tafinlar (dabrafenib).

Drug Name: Tafinlar (dabrafenib)

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 drug be used for 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 a 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 trametinib? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of central nervous system (CNS) cancer (i.e., glioma, oligodendroglioma, astrocytoma, glioblastoma)? [If no, then skip to question 9.]	Yes	No
7	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes	No

8	Will the requested drug be used in combination with trametinib? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of non-small cell lung cancer? [If no, then skip to question 12.]	Yes	No
10	Is the tumor positive for a BRAF V600E mutation? [If no, then no further questions.]	Yes	No
11	Will the requested drug be used as a single agent or in combination with trametinib? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of any of the following: A) gallbladder cancer, B) extrahepatic cholangiocarcinoma, C) intrahepatic cholangiocarcinoma? [If no, then skip to question 14.]	Yes	No
13	Is the patient's disease unresectable or metastatic? [If yes, then skip to question 23.] [If no, then no further questions.]	Yes	No
14	Does the patient have a diagnosis of ovarian cancer, fallopian tube cancer, or primary peritoneal cancer? [If no, then skip to questions 16.]	Yes	No
15	Will the requested drug be used to treat persistent or recurrent disease? [If yes, then skip to question 23.] [If no, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of anaplastic thyroid cancer? [If yes, then skip to question 18.]	Yes	No
17	Does the patient have a diagnosis of Langerhans Cell Histiocytosis or Erdheim-Chester Disease? [If no, then skip to question 19.]	Yes	No
18	Is the tumor positive for a BRAF V600E mutation? [No further questions.]	Yes	No
19	Does the patient have a diagnosis of papillary, follicular, or Hurthle cell thyroid carcinoma? [If no, then skip to question 22.]	Yes	No
20	Is the tumor BRAF-positive? [If no, then no further questions.]	Yes	No
21	Is the disease amenable to radioactive iodine (RAI) therapy? [No further questions.]	Yes	No
22	Does the patient have a diagnosis of solid tumor? [If no, then no further questions.]	Yes	No

23	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes	No
24	Will the requested drug be used in combination with trametinib?	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:_____