Prescriber Criteria Form Cotellic 2024 PA Fax 1307-A v2 010124.docx Cotellic (cobimetinib) 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 Cotellic (cobimetinib).

Drug Name: Cotellic (cobimetinib)

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 yes, then skip to question 6.]	Yes	No
2	Does the patient have a diagnosis of central nervous system (CNS) cancer? [If no, then skip to question 10.]	Yes	No
3	Is the patient diagnosed with one of following: A) glioma, B) glioblastoma, C) astrocytoma, D) oligodendroglioma? [If no, then no further questions.]	Yes	No
4	Does the patient have disease that is positive for BRAF V600E activating mutation? Please select 'No' if unknown. [If no, then no further questions.]	Yes	No
5	Will the requested drug be used in combination with vemurafenib? [No further questions.]	Yes	No
6	Will the requested medication be used for the adjuvant treatment of melanoma? [If yes, then skip to question 8.]	Yes	No
7	Does the patient have unresectable, limited resectable, or metastatic disease? [If no, then no further questions.]	Yes	No

8	Does the patient have disease that is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation)? Please select 'No' if unknown. [If no, then no further questions.]	Yes	No
9	Will the requested drug be used in combination with vemurafenib? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of histiocytic neoplasm? [If no, then no further questions.]	Yes	No
11	Will the requested drug be used as a single agent?	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:**_____