SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Zelboraf® (Vemurafenib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____**)** ***Start Date (or date of next dose):*** _____
Dose: _____ ***Regimen:*** _____

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. Will vemurafenib be used as a single-agent? Yes ☐ No ☐
2. Please indicate the diagnosis and information:
   - ☐ **Melanoma**
     - A. Is diagnosis unresectable or metastatic melanoma? Yes ☐ No ☐
     - B. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
     - C. Does member have wild-type BRAF melanoma? Yes ☐ No ☐
     - D. Will vemurafenib be used in combination with cobimetinib? Yes ☐ No ☐
     - E. Is vemurafenib being used as first-line therapy? Yes ☐ No ☐
     - F. Is vemurafenib being used as second-line or subsequent therapy? Yes ☐ No ☐
       - i. If being used as second-line or subsequent therapy, please provide member's ECOG performance status: _____
   - ☐ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Is the diagnosis refractory or metastatic disease? Yes ☐ No ☐
     - B. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
     - C. Does member have wild-type BRAF NSCLC? Yes ☐ No ☐
   - ☐ **Hairy-Cell Leukemia**
     - A. Is vemurafenib being used to treat disease progression following failure of purine analog therapy (i.e., pentostatin, cladribine)? Yes ☐ No ☐
   - ☐ **Erdheim-Chester Disease (ECD)**
     - A. Does member have BRAF V600E or V600K mutation? Yes ☐ No ☐
   - ☐ If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on vemurafenib? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to vemurafenib 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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*