Prescriber Criteria Form

Braftovi 2025 PA Fax 2615-A v1 010125.docx
Braftovi (encorafenib)
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 Braftovi (encorafenib).

Drug Name:
Braftovi (encorafenib)

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 7.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of colorectal cancer (including appendiceal adenocarcinoma)? [If no, then skip to question 11.]	Yes ◯	No ◯
3	Is the requested medication being used for primary treatment of unresectable metachronous metastases? [If yes, then skip to question 6.]	Yes ◯	No ◯
4	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
5	Will the requested drug be used as subsequent therapy? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the tumor positive for BRAF V600E mutation? [No further questions.]	Yes ◯	No ◯

7	Will the requested drug be used for adjuvant systemic therapy? [If yes, then skip to question 9.]	Yes ◯	No ◯
8	Is the disease unresectable, limited resectable, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
9	Does the patient have disease that is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation)? [If no, then no further questions.]	Yes ◯	No ◯
10	Will the requested drug be used as a single agent or in combination with binimetinib? [No further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes ◯	No ◯
12	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
13	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes ◯	No ◯
14	Will the requested drug be used in combination with binimetinib?	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:**_____