Prescriber Criteria Form

Tafinlar 2025 PA Fax 1000-A v1 010125.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 non-small cell lung cancer? [If no, then skip to question 9.]	Yes ◯	No ◯
7	Is the tumor positive for a BRAF V600E mutation? [If no, then no further questions.]	Yes ◯	No ◯
8	Will the requested drug be used as a single agent or in combination with trametinib? [No further questions.]	Yes ◯	No ◯

9	Does the patient have a diagnosis of anaplastic thyroid cancer? [If yes, then skip to question 11.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of Langerhans Cell Histiocytosis or Erdheim-Chester Disease? [If no, then skip to question 12.]	Yes ◯	No ◯
11	Is the tumor positive for a BRAF V600E mutation? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of papillary, follicular, or oncocytic thyroid carcinoma? [If no, then skip to question 15.]	Yes ◯	No ◯
13	Is the tumor BRAF-positive? [If no, then no further questions.]	Yes ◯	No ◯
14	Is the disease amenable to radioactive iodine (RAI) therapy? [No further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of solid tumor? [If no, then no further questions.]	Yes ◯	No ◯
16	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes ◯	No ◯
17	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:**_____