Prescriber Criteria Form

Zelboraf 2025 PA Fax 696-A v1 010125.docx
Zelboraf (vemurafenib)
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 Zelboraf (vemurafenib).

Drug Name:
Zelboraf (vemurafenib)

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 medication be used for the 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 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 cobimetinib? [No further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of central nervous system (CNS) cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma)? [If no, then skip to question 10.]	Yes ◯	No ◯
7	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes ◯	No ◯

8	Is the requested drug being used for the treatment of pediatric diffuse high-grade glioma? [If yes, then no further questions.]	Yes ◯	No ◯
9	Will the requested drug be used in combination with cobimetinib? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of Erdheim-Chester Disease (ECD) or Langerhans Cell Histiocytosis? [If no, then skip to question 12.]	Yes ◯	No ◯
11	Is the disease positive for a BRAF V600 mutation? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then skip to question 15.]	Yes ◯	No ◯
13	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
14	Is the tumor positive for a BRAF V600E mutation? [No further questions.]	Yes ◯	No ◯
15	Does the patient have a diagnosis of hairy cell leukemia?	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:**_____