SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Cotellic® (Cobimetinib) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

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. Diagnosis of unresectable or metastatic melanoma? Yes____ No____
   A. If answer is 'yes' to question 1, please check all of the following that apply:
      - ☐ BRAF V600E or V600K mutation detected by an FDA-approved test
      - ☐ Wild-type BRAF melanoma
      - ☐ Used as first-line therapy in combination with vemurafenib
      - ☐ Used as second-line therapy or subsequent therapy with vemurafenib
        i. If cobimetinib is being used as second-line therapy or subsequent therapy, please provide member's ECOG performance status (0-5): _____
2. If answer is 'no' to question 1, please provide diagnosis: _____

Additional Information: _____

_____

_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on cobimetinib? Yes____ No____
2. Has member experienced any adverse drug reactions related to cobimetinib 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.*