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 as detected by an FDA-approved test? 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 as detected by an FDA-approved test? 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
     - A. Does member have BRAF V600E or V600K mutation detected by an FDA-approved test? 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:

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

CONFIDENTIALITY NOTICE