

**State of Oklahoma  
Oklahoma Health Care Authority  
Mekinist® (Trametinib) 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:** \_\_\_\_\_ **Provider Name:** \_\_\_\_\_

**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Criteria**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Please indicate the diagnosis and information:

- Unresectable or metastatic melanoma
  - A. Does member have BRAF V600E or V600K mutation as detected by FDA-approved test? Yes \_\_\_ No \_\_\_
  - B. Does member have wild-type BRAF melanoma? Yes \_\_\_ No \_\_\_
  - C. Will trametinib be used as a single-agent? Yes \_\_\_ No \_\_\_
  - D. Will trametinib be used in combination with dabrafenib? Yes \_\_\_ No \_\_\_
  - E. Will trametinib be used as first-line therapy? Yes \_\_\_ No \_\_\_
  - F. Will trametinib be used as second-line or subsequent therapy? Yes \_\_\_ No \_\_\_
    - i. If using as second-line or subsequent therapy, please indicate member's ECOG performance status (0-5): \_\_\_\_\_
  - G. Has member received prior BRAF inhibitor therapy (e.g., dabrafenib, vemurafenib)? Yes \_\_\_ No \_\_\_
    - i. If member has received prior BRAF inhibitor therapy, please indicate the following:
      - a. Was member intolerant to prior BRAF inhibitor therapy? Yes \_\_\_ No \_\_\_
      - b. Was there evidence of progression on prior BRAF inhibitor therapy? Yes \_\_\_ No \_\_\_
- 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 \_\_\_
  - D. Will trametinib be used in combination with dabrafenib? Yes \_\_\_ No \_\_\_
- Anaplastic thyroid Cancer (ATC)
  - A. Is the diagnosis locally advanced or metastatic disease? Yes \_\_\_ No \_\_\_
  - B. Does member have BRAF V600E mutation as detected by an FDA-approved test? Yes \_\_\_ No \_\_\_
  - C. Will trametinib be used in combination with dabrafenib? Yes \_\_\_ No \_\_\_
  - D. Are there any satisfactory locoregional treatment options for the member? Yes \_\_\_ No \_\_\_
- If diagnosis is not listed above, please indicate diagnosis: \_\_\_\_\_

**For Continued Authorization:**

1. Does member have any evidence of progressive disease while on trametinib? Yes \_\_\_ No \_\_\_
2. Has the member experienced any adverse drug reactions related to trametinib therapy? Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

**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

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