OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Mekinist® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Anaplastic thyroid cancer (ATC)
❑ Melanoma
❑ Non-small cell lung cancer
❑ Other diagnosis: ____ ICD-10 Code(s): ___________________________________

Clinical Information:

Will Mekinist be used in combination with Tafinlar (dabrafenib)? ❑ **Yes** ❑ **No**
Is Mekinist prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Select if the cancer has the following mutation type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA):
❑ BRAF V600E ❑ BRAF V600K

For anaplastic thyroid cancer (ATC), also answer the following:

Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**
Can the cancer be treated with standard locoregional treatment options? ❑ **Yes** ❑ **No**

For melanoma, also answer the following:

Does the patient have metastatic or unresectable disease? ❑ **Yes** ❑ **No**
Is Mekinist being used as adjuvant treatment for melanoma? ❑ **Yes** ❑ **No**
Does the patient have involvement of lymph nodes following complete resection? ❑ **Yes** ❑ **No**

For non-small cell lung cancer, also answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Mekinist therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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