Cotellic® Prior Authorization Request Form

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

**Medication Information** (required)

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
<th>Dosage Form:</th>
</tr>
</thead>
</table>
- Check if requesting brand
- Check if request is for continuation of therapy

**Clinical Information** (required)

Select the diagnosis below:
- Melanoma
- Other diagnosis: ____________ ICD-10 Code(s): ______________________

Clinical Information:

Does the patient have unresectable or metastatic disease?  □ Yes  □ No

Select if the patient has one of the following mutations as detected by an FDA-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA):
- BRAF V600E
- BRAF V600K

Will Cotellic be used in combination with Zelboraf (vemurafenib)?  □ Yes  □ No

Is Cotellic prescribed by or in combination with an oncologist?  □ Yes  □ No

Is this request for continuation of prior Cotellic therapy?  □ Yes  □ No

Has the patient used Cotellic in the past 120 days?  □ Yes  □ No

**Quantity Limit:**

What is the quantity requested per DAY? ______

What is the reason for exceeding the plan limitations?
- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dosage is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: ________________________________
- Other: __________________________________________

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

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please note: This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

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.