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Medicare Part D Prescription Coverage Request Form - *BRAFTOVI*

View our formulary on line at https://www.blueshieldca.com/med_formulary

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Important Note: Expedited Decisions

If the standard decision time of 72 hours or less may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited (fast) decision can be requested.

☐ CHECK THIS BOX IF A DECISION NEEDS TO BE GIVEN WITHIN 24 HOURS.

Date of Request:

Physician Information	**Patient Information**
Physician's Name: ☐ PCP; ☐ Specialist: _____ Office contact:_____ Phone#: ( ) Facsimile #: ( )	Patient's Name: Patient's Address: Blue Shield ID#: Birthdate: **Patient's height/weight:** Drug Allergies:

STRENGTH:	QUANTITY:	EXPECTED LENGTH OF THERAPY:
DIRECTIONS:		
DIAGNOSIS:	ICD-10 CODE:	

PATIENT CLINICAL INFORMATION

1. Has the patient been started on the medication? ☐ YES ☐ NO. If yes, please provide date therapy was started.

2. Has the disease progressed to other areas of the body (metastatic)? ☐ NO ☐ YES

3. Is the patient able to undergo surgical intervention? ☐ NO ☐ YES

4. Has patient tested positive for the BRAF V600E or V600K gene mutation? ☐ NO ☐ YES

FAX form to: 1(888)697-8122 | **Pharmacy Services Phone #: 1(800)535-9481**

Effective: 10/01/2018

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5. What other medications will be used with Braftovi?

6. Has the patient previously been treated with a BRAF inhibitor (e.g. Tafinlar, Zelboraf)?
☐ NO ☐ YES

7. Do you believe one or more of the coverage requirements should be waived? ☐ NO ☐ YES
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

_____
_____
_____
_____
_____

8. Additional information we should consider *(attach any supporting documents)*:

_____
_____
_____

Provider Signature:	**Date:**

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