Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Braftovi
(encorafenib)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Braftovi 50mg ☐ Braftovi 75mg ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ melanoma ☐ colorectal cancer (CRC) ☐ other *(please specify):*

Clinical Information

(if melanoma) Does your patient have documented V600E or V600K mutation of the BRAF gene? Yes ☐ No ☐
(if melanoma) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐
(if melanoma) Will the drug requested be given in combination with binimetinib(Mektovi)? Yes ☐ No ☐

(if CRC) Does your patient have a V600e mutation of the BRAF gene? Yes ☐ No ☐
(if CRC w/V600e) Does your patient have metastatic disease? Yes ☐ No ☐
(if CRC w/V600e) Will the drug requested be given in combination with cetuximab (Erbitux)? Yes ☐ No ☐
(if CRC) Does your patient have a V600 mutation of the BRAF gene? Yes ☐ No ☐
(if CRC) Does your patient have unresectable, advanced or metastatic disease? Yes ☐ No ☐
(if CRC) Is/Will the requested medication be(ing) used in combination with Mektovi (binimetinib) AND either Erbitux (cetuximab) or Vectibix (panitumumab)? Yes ☐ No ☐
(if CRC) Has your patient previously received any chemotherapy for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with either Erbitux (cetuximab) or Vectibix (panitumumab) for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with oxaliplatin-based therapy without irinotecan (Camptosar) for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with irinotecan (Camptosar)-based therapy without oxaliplatin for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with FOLFOXIRI (fluorouracil, 5-FU [Adrucil]; leucovorin; oxaliplatin; irinotecan [Camptosar]) regimen for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with a fluoropyrimidine (like capecitabine [Xeloda], floxuridine, or fluorouracil [Adrucil, 5-FU] without irinotecan (Camptosar) or oxaliplatin, followed by FOLFOX (fluorouracil [Adrucil, 5-FU]; leucovorin; oxaliplatin) with or without Avastin (bevacizumab) for this diagnosis? Yes ☐ No ☐
(if CRC) Has your patient previously been treated with a fluoropyrimidine (like capecitabine [Xeloda], floxuridine, or fluorouracil [Adrucil, 5-FU] without irinotecan (Camptosar) or oxaliplatin, followed by CapeOX (capecitabine [Xeloda] and oxaliplatin) with or without Avastin (bevacizumab) for this diagnosis? Yes ☐ No ☐

Additional pertinent information *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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