Prescriber Criteria Form Mekinist 2026 PA Fax 999-A v2 010126.docx Mekinist (trametinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Mekinist (trametinib).

Drug Name: Mekinist (trametinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of uveal melanoma? [If no, then skip to question 3.]	Yes	No
2	Will the requested drug be used as a single agent? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of melanoma? [If no, then skip to question 8.]	Yes	No
4	Will the requested drug be used for adjuvant or neoadjuvant treatment of melanoma? [If yes, then skip to question 6.]	Yes	No
5	Is the melanoma unresectable, limited resectable, or metastatic? [If no, then no further questions.]	Yes	No
6	Will the requested drug be used as a single agent or in combination with dabrafenib? [If no, then no further questions.]	Yes	No
7	Is the tumor positive for a BRAF mutation? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of ovarian cancer, fallopian tube cancer, or primary peritoneal cancer? [If no, then skip to question 10.]	Yes	No

9	Will the requested drug be used to treat persistent or recurrent disease? [No further questions.]	Yes	No
10	Does the patient have any of the following diagnoses: A) Langerhans Cell Histiocytosis, B) Erdheim-Chester Disease, C) Rosai-Dorfman Disease? [If yes, then no further questions.]	Yes	No
11	Does the patient have a diagnosis of papillary, follicular, or oncocytic thyroid carcinoma? [If no, then skip to question 13.]	Yes	No
12	Is the disease amenable to radioactive iodine (RAI) therapy? [If yes, then no further questions.] [If no, then skip to question 16.]	Yes	No
13	Does the patient have a diagnosis of hairy cell leukemia? [If no, then skip to question 15.]	Yes	No
14	Has the patient had previous treatment with BRAF inhibitor therapy? [If yes, then no further questions.] [If no, then skip to question 17.]	Yes	No
15	Does the patient have a diagnosis of solid tumor? [If no, then no further questions.]	Yes	No
16	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes	No
17	Will the requested drug be used in combination with dabrafenib?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____