Prescriber Criteria Form Mektovi 2026 PA Fax 2613-A v1 010126.docx Mektovi (binimetinib) 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 Mektovi (binimetinib).

Drug Name: Mektovi (binimetinib)

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 melanoma? [If no, then skip to question 6.]	Yes	No
2	Is the requested drug being used for adjuvant or neoadjuvant systemic therapy? [If yes, then skip to question 4.]	Yes	No
3	Is the disease unresectable, limited resectable, or metastatic? [If no, then no further questions.]	Yes	No
4	Does the patient have disease that is positive for BRAF V600 activating mutation (e.g., V600E or V600K)? [If no, then no further questions.]	Yes	No
5	Will the requested drug be used in combination with encorafenib? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of Langerhans Cell Histiocytosis? [If yes, then no further questions.]	Yes	No
7	Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? [If no, then no further questions.]	Yes	No
8	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes	No

9	Is the tumor positive for BRAF V600E mutation? [If no, then no further questions.]	Yes	No
10	Will the requested drug be used in combination with encorafenib?	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:_____