P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Zelboraf™
(vemurafenib)

Therapeutic use: Treatment of unresectable or metastatic melanoma in patients with $BRAF^{V600E}$ mutation
Quantity Limit: 960 mg orally twice daily (8 tablets per day)
Authorization Period: 12 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescribing physician an oncologist or hematologist?	❑ Yes	❑ No
2.	Does the patient have unresectable or metastatic melanoma?	❑ Yes	❑ No
3.	Is the patient $BRAF^{V600E}$ mutation positive?	❑ Yes	❑ No
4.	Is Zelboraf being used in monotherapy?	❑ Yes	❑ No
• QT prolongation has been reported with Zelboraf. ECG should be monitored at baseline, day 15, monthly for the first 3 months of treatment and every 3 months thereafter.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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