TEXAS MEDICAID
Clinical Edit Prior Authorization
vemurafenib (ZELBORAF)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is vemurafenib (ZELBORAF) being prescribed by, or its use being overseen, by an oncologist? [Manual Step]

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of unresectable or metastatic melanoma or Erdheim-Chester disease in the last 365 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Has the presence of the BRAF V600E mutation been confirmed? [Manual Step]

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have one (1) claim for a strong CYP3A4 inhibitor/inducer or a CYP1A2 substrate with a narrow therapeutic index in the last 90 days?

   Examples include carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), phenobarbital, phenytoin (DILANTIN, PHENYTEK), pioglitazone (ACTOS, ACTOPLUS, DUETACT, OSENI), rifampin (RIFADIN), rifabutin (MYCOBUTIN), clarithromycin (BIAXIN), telithromycin (KETEK), ketoconazole, itraconazole (SPORANOX), posaconazole (NOXAFIL), voriconazole (VFEND), diltiazem (CARDIZEM, TIAZAC), ORKAMBI, TAFINLAR, XTANDI, ZYDELIG, theophylline, warfarin (COUMADIN, JANTOVEN), and certain HIV treatments (ATRIPLA, CRIXIVAN, GENVOYA, INVIRASE, KALETRA, nevirapine, NORVIR, PREZCOBIX, STRIBILD, SUSTIVA, VIRACEPT, VIRAMUNE).

   ☐ Yes (Deny) ☐ No (Approve - 365 days)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.