

Ibrance® (palbociclib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Please indicate the diagnosis and information:

 Breast Cancer

- Is diagnosis advanced, metastatic disease? Yes No
- Is disease human epidermal receptor type 2 (HER2)-negative? Yes No
- Is disease hormone receptor positive? Yes No
- Will palbociclib be used in combination with an aromatase inhibitor for a female?
Yes No
- Will palbociclib be used in combination with fulvestrant for a female with disease progression following endocrine therapy? Yes No
- Will palbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male?
Yes No
- Will palbociclib be used in combination with inavolisib and fulvestrant for a member with disease progression following endocrine therapy? Yes No

 Other: _____**For Continued Authorization:**

- Date of last dose: _____
- Does member have any evidence of progressive disease while on palbociclib (when used for metastatic disease only)? Yes No
- Has the member experienced any adverse drug reactions related to palbociclib therapy?
Yes No

If yes, please specify adverse reactions: _____

Additional Information: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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