

**Itovebi™ (inavolisib) 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**

1. Please indicate the diagnosis and information:

 **Breast Cancer**A. Is diagnosis locally advanced or metastatic disease? Yes  No B. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes  No C. Is disease hormone receptor (HR)-positive? Yes  No D. Is disease PIK3CA-mutated? Yes  No E. Will inavolisib be used in combination with palbociclib and fulvestrant? Yes  No F. Will inavolisib be used following recurrence on or after completing adjuvant therapy? Yes  No  **If diagnosis is none of the above, please indicate diagnosis:** \_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on inavolisib? Yes  No 3. Has the member experienced any adverse drug reactions related to inavolisib 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](http://AetnaBetterHealth.com/Oklahoma).

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