1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Ibrance® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Breast cancer

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**

Does the patient have estrogen-receptor (ER)-positive disease? ❑ **Yes** ❑ **No**

Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease? ❑ **Yes** ❑ **No**

Select if the patient will use Ibrance in combination with the following:

- ❑ Aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)
- ❑ Femara (letrozole)
- ❑ Faslodex (fulvestrant)

Has the disease progressed following endocrine therapy? ❑ **Yes** ❑ **No**

Is the patient a postmenopausal female? ❑ **Yes** ❑ **No**

If ”no”, is the patient a premenopausal or perimenopausal female and receiving a luteinizing hormone-releasing hormone (LHRH) agonist [e.g., Zoladex (goserelin)]? ❑ **Yes** ❑ **No**

Is Ibrance prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Ibrance therapy? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	