



### Verzenio® (Abemaciclib) Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

#### Drug Information

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

Dose: \_\_\_\_\_ Dosing Regimen: \_\_\_\_\_

#### Billing Provider Information

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider 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 diagnosis and information:

**Advanced or Metastatic Breast Cancer**

- A. Is disease hormone receptor (HR)-positive? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes \_\_\_\_\_ No \_\_\_\_\_
  - i. Will abemaciclib be used in combination with an aromatase inhibitor as initial endocrine-based therapy for postmenopausal women? Yes \_\_\_\_\_ No \_\_\_\_\_
  - ii. Will abemaciclib be used in combination with fluvestrant with disease progression following endocrine therapy? Yes \_\_\_\_\_ No \_\_\_\_\_
  - iii. Will abemaciclib be used as monotherapy for disease progression following endocrine therapy and prior chemotherapy? Yes \_\_\_\_\_ No \_\_\_\_\_

**Early-Stage Breast Cancer**

- A. Is disease HR-positive? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Is disease HER2-negative? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Is disease node-positive with high risk for recurrence? Yes \_\_\_\_\_ No \_\_\_\_\_
- D. Will abemaciclib be used as adjuvant treatment in combination with endocrine therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

**If diagnosis is not listed above, please provide diagnosis:** \_\_\_\_\_

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

**For Continued Authorization:**

- 1. Date of last dose: \_\_\_\_\_
  - 2. Does member have any evidence of progressive disease while on abemaciclib? Yes \_\_\_\_\_ No \_\_\_\_\_
  - 3. Has member experienced adverse drug reactions related to abemaciclib therapy? Yes \_\_\_\_\_ No \_\_\_\_\_
- If yes, please specify adverse reactions: \_\_\_\_\_

**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. Failure to complete this form in full will result in processing delays.*

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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