OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
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:_____

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 the diagnosis and information:
   - ❑ **Breast Cancer**
     - A. Is diagnosis advanced, metastatic disease? Yes____ No____
     - B. Is disease human epidermal receptor type 2 (HER2)-negative? Yes____ No____
     - C. Is disease hormone receptor positive? Yes____ No____
     - D. Will palbociclib be used in combination with an aromatase inhibitor for a postmenopausal female? Yes____ No____
     - E. Will palbociclib be used in combination with fulvestrant for a female with disease progression following endocrine therapy? Yes____ No____
     - F. Will palbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male? Yes____ No____
   - ❑ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____
_____

For Continued Authorization:

1. Does patient have any evidence of progressive disease while on palbociclib (when used for metastatic disease only)? Yes____ No____
2. 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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OHCA Approved 12/7/2021