SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
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: _____ ***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:
   - ☐ Breast Cancer
     - A. Advanced or metastatic breast cancer? Yes____ No____
     - B. Progressed after endocrine therapy when used with fluvestrant or as initial therapy in combination with an aromatase inhibitor? Yes____ No____
     - C. Hormone receptor (HR)-positive? Yes____ No____
     - D. Human epidermal growth factor receptor 2 (HER2)-negative? Yes____ No____
     - E. Will abemaciclib be used in combination with an aromatase inhibitor as initial endocrine -base therapy for postmenopausal women? Yes____ No____
     - F. Will abemaciclib be used in combination with fulvestrant with disease progression following endocrine therapy in advanced or metastatic breast cancer? Yes____ No____
     - G. Will abemaciclib be used as monotherapy for disease progression following endocrine therapy and prior chemotherapy in metastatic breast cancer? Yes____ No____
   - ☐ Other, 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.

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

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