Ibrance (palbocicclib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Breast cancer**	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ **Yes** ☐ **No**

Does the patient have estrogen receptor positive advanced breast cancer? ☐ **Yes** ☐ **No** ***Please submit documentation.***

Is the patient's breast cancer HER-2 negative? ☐ **Yes** ☐ **No** ***Please submit documentation.***

Has the patient received prior treatment with fulvestrant? ☐ **Yes** ☐ **No** ***Documentation of all previous treatment regimens required.***

Has the patient received prior treatment with everolimus? ☐ **Yes** ☐ **No** ***Documentation of all previous treatment regimens required.***

Has the patient received prior treatment with endocrine therapy? ☐ **Yes** ☐ **No** ***Documentation of all previous treatment regimens required.***

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

Is the patient a pre/perimenopausal female? ☐ **Yes** ☐ **No**

Is the patient male? ☐ **Yes** ☐ **No**

Will the patient use letrozole, anastrazole or exemestine in combination with Ibrance (palbociclib)? ☐ **Yes** ☐ **No**

Will the patient use fulvestrant in combination with Ibrance (palbociclib)? ☐ **Yes** ☐ **No**

Will the patient use letrozole, anastrazole or exemestine in combination with goserelin(Zoladex) and Ibrance(palbociclib)? ☐ **Yes** ☐ **No**

Renewal Requests:

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Is patient continuing to demonstrate a positive clinical response? □ **Yes** □ **No** ***Please submit documentation.***

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

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program;
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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