Kisqali (ribociclib)
Prior Authorization Request Form

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

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

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 ☐ Other Diagnosis_____ICD-10 Code(s):_____	

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

Clinical Information:

Initial Request:

Is Kisqali(ribociclib) going to be used in conjunction with a clinical study? ☐ Yes ☐ No

Does the patient have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor-2 (HER-2)-negative advanced or metastatic breast cancer? ☐ Yes ☐ No Please provide chart documentation.

Is patient POST-menopausal? ☐ Yes ☐ No

Is patient PRE-menopausal or PERI-menopausal? ☐ Yes ☐ No

Is patient a male? ☐ Yes ☐ No

Has the patient received a previous treatment with palbociclib (Ibrance ®)? ☐ Yes ☐ No Please provide chart documentation.

Has the patient received previous treatment with abemaciclib (Verzenio®)? ☐ Yes ☐ No Please provide chart documentation.

Has the patient received any previous systemic chemotherapy for advanced disease? ☐ Yes ☐ No Please provide chart documentation.

Has the patient received any previous endocrine therapy for advanced disease? ☐ Yes ☐ No Please provide chart documentation.

Has patient received endocrine therapy for advanced disease within the past one month of requesting Kisqali? ☐ Yes ☐ No

Has patient received more than one previous systemic chemotherapy for advanced disease? ☐ Yes ☐ No

Will the patient use the aromatase inhibitor letrozole in combination with Kisqali (ribociclib)? ☐ Yes ☐ No

Has the patient been previously treated with fulvestrant? ☐ Yes ☐ No

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Will the patient be using fulvestrant in combination with Kisqali? □ **Yes** □ **No**

Will the patient be using goserelin in combination with Kisqali? □ **Yes** □ **No**

Will the patient be using tamoxifen in combination with Kisqali? □ **Yes** □ **No**

Will the patient be using anastrozole in combination with Kisqali? □ **Yes** □ **No**

Renewal Request:
Is the patient continuing to have a positive clinical response? □ **Yes** □ **No** **Please provide chart 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:** _____

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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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