



Verzenio (Abemaciclib)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit



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](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: |
| <input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL | | IF RENEWAL: DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

Continued on next page.





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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 _____

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

Clinical Information:
Please submit chart documentation to substantiate all questions below.

Will Verzenio be used in conjunction with a clinical trial? 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 with disease progression? Yes No

Has the patient had previous trial with more than one endocrine based therapy such as tamoxifen, Fareston (toremifene), anastrozole, letrozole, or exemestane for advanced disease?* Yes No
 *Chart documentation is required.

Will Verzenio be used in combination with Faslodex (fulvestrant)? Yes No

Has the patient had prior treatment with Faslodex (fulvestrant), Afinitor (everolimus), OR another CDK4/CDK6 inhibitor such as Ibrance (palbociclib) or ribociclib/ Kisqali? Yes No

Has the patient had prior use of chemotherapy for advanced disease? Yes No

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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

