OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

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: _____ ***Dosing 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:
   - ❑ **Advanced or Metastatic Breast Cancer**
     - A. Is disease hormone receptor (HR)-positive? Yes____ No____
     - B. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes____ No____
       - i. Will abemaciclib be used in combination with an aromatase inhibitor as initial endocrine-based therapy for postmenopausal women? Yes____ No____
       - ii. Will abemaciclib be used in combination with fluvestrant with disease progression following endocrine therapy? Yes____ No____
       - iii. Will abemaciclib be used as monotherapy for disease progression following endocrine therapy and prior chemotherapy? Yes____ No____
   - ❑ **Early-Stage Breast Cancer**
     - A. Is disease HR-positive? Yes____ No____
     - B. Is disease HER2-negative? Yes____ No____
     - C. Is disease node-positive with high risk for recurrence? Yes____ No____
     - D. Is Ki-67 ≥20%? Yes____ No____
     - E. Will abemaciclib be used as adjuvant treatment in combination with endocrine therapy? Yes____ No____
   - ❑ **If diagnosis is not listed above, 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. *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