



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? 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. 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.

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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