SoonerSelect | aetna

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. 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: ____

DRAFT

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.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.	CONFIDENTIALITY NOTICE *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.*