Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Ibrance® (palbociclib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Ibrance 75 mg capsule
- ☐ Ibrance 100 mg capsule
- ☐ Ibrance 125 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Ibrance is $564.60 for each capsule. The annual cost of treatment with this drug is more than $154,559.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for advanced or metastatic estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer
    a. In combination with fulvestrant for progression following endocrine therapy
    b. In combination with an aromatase inhibitor as initial treatment in postmenopausal women

Additional information

Note: Coverage is provided for 1 year per approved authorization

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 03/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Advanced or metastatic breast cancer that is ER-positive and HER2-negative
- ☐ *Other – the patient's condition is:* _____

B. Is Ibrance being used following progression on endocrine therapy?

- ☐ Yes; *Endocrine therapy used:* _____
- ☐ No

C. Is Ibrance being used as initial therapy?

- ☐ Yes
- ☐ No

D. Is the patient post-menopausal?

- ☐ Yes
- ☐ No

E. Will the patient be taking either of the following in combination with Ibrance?

- ☐ Yes, letrozole
- ☐ Yes, fulvestrant
- ☐ No; *Rationale*: _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Ibrance likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

If the patient is currently using Ibrance would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: _____

_____

_____

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Updated 01/2018
Last reviewed 03/2019