PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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

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 prescribed for the treatment of estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer
2. Must be taken in combination with a. or b.:
    a. An aromatase inhibitor (e.g. letrozole) as initial endocrine-based therapy in postmenopausal women or in men; or
    b. Fulvestrant in patients with disease progression following endocrine therapy
3. Cannot have previous disease progression on Ibrance or Kisqali.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

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

Updated 05/2017
Last reviewed 11/2019

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Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer

☐ *Other – the patient's condition is:* _____

B. The patient will also be taking:

☐ letrozole

☐ fulvestrant (Faslodex)

C. Is the patient pre or postmenopausal?

☐ **Premenopausal**

☐ **Postmenopausal**

D. Has the patient previously used any other medications for their breast cancer?

☐ **Yes, *please list drugs and dates*:**

_____

_____

☐ **No**

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