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.

Kisqali® Femara® Co-Pack (ribociclib/letrozole)

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:
☐ Kisqali Femara Co-Pack 200mg/2.5 mg tablet
☐ Kisqali Femara Co-Pack 400mg/2.5 mg tablet
☐ Kisqali Femara Co-Pack 600mg/2.5 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Requested Duration: _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically-accepted indication*
2. For advanced or metastatic breast cancer, the patient must be hormone-receptor (HR)-positive and human epidermal growth factor receptor 2 (HER-2) negative

Additional information

Note: When criteria are met, coverage is provided for 1 year.

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. No changes made since 01/2018
Last reviewed 01/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Advanced breast cancer
- ☐ Metastatic breast cancer
- ☐ *Other – the patient's condition is:* _____

B. Is the patient HR-positive and HER2 negative?

☐ Yes ☐ No

C. Is the patient post-menopausal?

☐ Yes ☐ No

D. Is Kisqali Femara being used as initial endocrine-based treatment?

☐ Yes ☐ No

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 Kisqali Femara Co-Pack likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Kisqali Femara Co-Pack, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 01/2019