

# Priority Health Medicare Prior Authorization Criteria (Part D)

## Ibrance®

### Products affected

- Ibrance®

### Details

<b>Covered uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion criteria</b>	N/A
<b>Required medical information</b>	N/A
<b>Age restrictions</b>	N/A
<b>Prescriber restrictions</b>	N/A
<b>Coverage duration</b>	One year
<b>Other criteria</b>	N/A