

## Inluriyo™ (imlunestrant) 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: \_\_\_\_\_

### Pharmacy Information

Pharmacy NPI: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

### Prescriber Information

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

### Criteria

#### For Initial Authorization:

##### 1. Please indicate the diagnosis and information:

**Breast Cancer**

A. Is diagnosis advanced or metastatic breast cancer? Yes \_\_\_ No \_\_\_

B. Is disease estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative? Yes \_\_\_ No \_\_\_

C. Is tumor positive for estrogen receptor-1 (ESR-1) mutation? Yes \_\_\_ No \_\_\_

D. Has disease progressed following at least 1 line of endocrine therapy? Yes \_\_\_ No \_\_\_

**Other:** \_\_\_\_\_

#### For Continued Authorization:

1. Date of last dose: \_\_\_\_\_

2. Does the member have any evidence of progressive disease while on imlunestrant? Yes \_\_\_ No \_\_\_

3. Has the member experienced any adverse drug reactions related to imlunestrant therapy?

Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

Additional Information: \_\_\_\_\_

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.**

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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