State of Oklahoma
SoonerCare
Ibrance® (palbociclib) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose:_____ 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 (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:
   - ☐ **Breast Cancer**
     a. Is diagnosis locally advanced or metastatic, hormone receptor positive disease? Yes☐ No☐
        - ☐ **For human epidermal growth factor receptor type 2 (HER2)-negative disease**:
          i. Will palbociclib be used in combination with an aromatase inhibitor for a female? Yes☐ No☐
          ii. Will palbociclib be used in combination with fulvestrant for a female with disease progression following endocrine therapy? Yes☐ No☐
          iii. Will palbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male? Yes☐ No☐
          iv. Will palbociclib be used in combination with inavolisib and fulvestrant for a member with disease progression following endocrine therapy? Yes☐ No☐
        - ☐ **For human epidermal growth factor receptor 2 (HER2)-positive disease:**
          i. Will palbociclib be used in combination with trastuzumab, with or without pertuzumab, and endocrine therapy? Yes☐ No☐
          ii. Will palbociclib be used as maintenance treatment following induction treatment? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please provide diagnosis:** _____

Additional Information: _____

_____

_____

DRAFT

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on palbociclib (when used for metastatic disease only)? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to palbociclib therapy? Yes ☐ No ☐
   If yes, please specify adverse reactions: _____

Additional Information: _____

_____

_____

_____

_____

DRAFT

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. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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