State of Oklahoma
SoonerCare

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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:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider 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 advanced, metastatic disease? Yes☐ No☐
B. Is disease human epidermal receptor type 2 (HER2)-negative? Yes☐ No☐
C. Is disease hormone receptor positive? Yes☐ No☐
D. Will palbociclib be used in combination with an aromatase inhibitor for a female? Yes☐ No☐
E. Will palbociclib be used in combination with fulvestrant for a female with disease progression following endocrine therapy? Yes☐ No☐
F. Will palbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

_____

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: _____

_____

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.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.