

State of Oklahoma
 Oklahoma Health Care Authority
**Kisqali® Femara® Co-Pack (Ribociclib/Letrozole) and Kisqali®
 (Ribociclib) Prior Authorization Form**

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

Drug Information

Drug Name: _____ **Strength:** _____ **Pharmacy billing (NDC:** _____ **)**
Daily Dose: _____ **Refill Number:** _____ **Start Date (or date of next dose):** _____

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:

1. Diagnosis of advanced or metastatic breast cancer? Yes ___ No ___
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Is this being used for first line use? Yes ___ No ___
4. Please indicate requested information:
 - Negative expression of Human Epidermal Receptor Type 2 (HER2)
 - Patient is postmenopausal
 - Estrogen receptor (ER)-positive
5. Will Kisqali® be used in combination with an aromatase inhibitor? Yes ___ No ___
6. Will Kisqali® be used in combination with fulvestrant? Yes ___ No ___
 - b. If answer is 'yes' from previous question, is this being used as initial endocrine based therapy or following disease progression on endocrine therapy? Yes ___ No ___

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does patient have any evidence of progressive disease while on ribociclib? Yes ___ No ___
3. Has the member experienced any adverse drug reactions related to ribociclib 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.**

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