Verzenio (abemaciclib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	**FIRST NAME:**	
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**	
NPI NUMBER:	**DEA NUMBER:**	
PHONE NUMBER:	**FAX NUMBER:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Breast cancer ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Does the patient have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative advanced or metastatic breast cancer with disease progression[MONARCH 2]? □ **Yes** □ **No Chart documentation is required.**

Has the patient had previous trial with more than one endocrine based therapy such as tamoxifen, Fareston (toremifene), anastrozole, letrozole, or exemestane for advanced disease?* □ **Yes** □ **No**
***Chart documentation is required.**

Will Verzenio be used in combination with Faslodex (fulvestrant)? □ **Yes** □ **No**

Has the patient had prior treatment with Faslodex (fulvestrant), Afinitor (everolimus), OR another CDK4/CDK6 inhibitor such as Ibrance (palbociclib) or ribociclib/ Kisqali? □ **Yes** □ **No Chart documentation is required.**

Excluding any adjuvant or neoadjuvant endocrine therapy in the past, has the patient had prior use of chemotherapy for advanced disease? □ **Yes** □ **No Chart documentation is required.**

<u>For patients with Early Breast Cancer, please answer the following[MONARCH E]</u>:
Does patient have HR-positive, HER2-negative, node-positive, early breast cancer? □ **Yes** □ **No Chart documentation is required.**

Does patient have pathologic lymph node involvement and at least one of the following indicating a higher risk of recurrence? □ **Yes** □ **No Chart documentation is required.**
□ **4 or more positive axillary lymph nodes**
□ **Tumor size of at least 5 centimeters**
□ **Grade 3 defined as at least 8 points on the Bloom Richardson grading system**
□ **Ki-67 index by central analysis of ≥20% on untreated breast tissue**

Does patient have metastases? □ **Yes** □ **No**

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Has patient undergone definitive surgery of the primary breast tumor? □ Yes □ No Chart documentation is required.

Does patient have inflammatory breast cancer? □ Yes □ No

Does patient have a history of previous breast cancer, with the exception of ipsilateral ductal carcinoma in situ(DCIS) treated by locoregional therapy alone greater than or equal to 5 years ago? □ Yes □ No Chart documentation is required.

Has patient been previously treated with any CDK4/CDK6 inhibitor(such as palbociclib/ Ibrance® or ribociclib/ Kisqali®)? □ Yes □ No Chart documentation is required.

Has patient received prior endocrine therapy for breast cancer prevention(tamoxifen, or aromatase inhibitors or raloxifene? □ Yes □ No

Will Verzenio(abemaciclib) be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor)? □ Yes □ No

Does patient have HR-positive, HER2-negative, advanced breast cancer[MONARCH 3]? □ Yes □ No

Is patient post-menopausal? □ Yes □ No

Excluding any adjuvant or neoadjuvant endocrine therapy in the past, has the patient received systemic therapy for advanced disease? □ Yes □ No

Does patient have CNS metastasis? □ Yes □ No

Has patient had prior treatment with a CDK4/6 inhibitor (such as palbociclib/ Ibrance® or ribociclib/ Kisqali®)?□ Yes □ No

Has patient had prior treatment with everolimus(Afinitor)? □ Yes □ No

Will Verzenio® (abemaciclib) be used in combination with letrozole or anastrozole? □ Yes □ No

For patients who have received past adjuvant or neoadjuvant endocrine therapy ONLY, has patient had a disease-free interval of more than 12 months from the completion of endocrine therapy? □ Yes □ No

Renewal Request:
Is patient continuing to demonstrate a positive clinical response? □ Yes □ No Chart documentation is required.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
Phone: 877-228-7909

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