Itovebi (invalisib)
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 patient have confirmed diagnosis of HR+/HER2- breast cancer? ☐ **Yes** ☐ **No Please submit documentation.**

Does patient have metastatic or locally advanced disease not amenable to curative therapy? ☐ **Yes** ☐ **No Please submit documentation.**

Does patient have progression of disease during adjuvant endocrine treatment or within 12 months of completing adjuvant endocrine therapy with an aromatase inhibitor or tamoxifen? ☐ **Yes** ☐ **No Please submit documentation.**

If patient is pre/peri-menopausal, has patient received LHRH agonist therapy for at least 2 weeks prior to Day 1 of Cycle 1 of Itovebi(invalisib)? ☐ **Yes** ☐ **No Please submit documentation.**

Does patient have confirmation of PIK3CA mutation(s)? ☐ **Yes** ☐ **No Please submit documentation.**

Is patient ECOG of 0 or 1? ☐ **Yes** ☐ **No**

Does patient have metaplastic breast cancer? ☐ **Yes** ☐ **No**

Has patient had any prior systemic therapy for metastatic breast cancer? ☐ **Yes** ☐ **No Please submit documentation.**

Has patient had prior treatment with fulvestrant or any selective estrogen-receptor degrader as part of neoadjuvant therapy? ☐ **Yes** ☐ **No Please submit documentation.**

If YES to above question, was treatment duration longer than 6months? ☐ **Yes** ☐ **No Please submit documentation.**

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Has patient had prior treatment with fulvestrant or any selective estrogen-receptor degrader NOT as part of neoadjuvant therapy? ☐ **Yes** ☐ **No Please submit documentation.**

Has patient had prior treatment with any PI3K, AKT, or mTOR inhibitor, or any agent whose mechanism of action is to inhibit the PI3K-AKT-mTOR pathway? ☐ **Yes** ☐ **No Please submit documentation.**

Will Itovebi(invalisib) be used in combination with Ibrance(palbociclib) and fulvestrant? ☐ **Yes** ☐ **No Please submit documentation.**

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

_____

_____

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:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909