OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: Verzenio® (abemaciclib)

***DRUG INFORMATION:* Complete all information below or authorization process will be delayed.**

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

***Quantity limit*: 68 tablets/34 days**

***CLINICAL CRITERIA:* To receive a ONE (1) year approval for this drug, all information below must be checked to qualify to ensure authorization process will NOT be delayed. Chart notes/lab results MUST BE INCLUDED with this request form.**

1. Is member taking Verzenio® in combination with fulvestrant for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy? ❑ Yes ❑ No
2. Is member taking Verzenio® as monotherapy for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting? ❑ Yes ❑ No
3. Is member taking Verzenio® in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer? ❑ Yes ❑ No
4. Is the prescriber an oncologist? ❑ Yes ❑ No
5. Is member ≥ 18 years of age? ❑ Yes ❑ No
6. If female, is member pregnant or breast feeding? ❑ Yes ❑ No

- **If approved, monitor complete blood counts prior to the start of Verzenio® therapy, every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated.**
- **If approved, perform liver function tests (LFTs) before initiating treatment with Verzenio®. Monitor LFTs every 2 weeks for the first 2 months, monthly for the next 2 months, and as clinically indicated**.

***Medication being provided by a Specialty Pharmacy* - PropriumRx**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. *

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~7/1/2018;~~ **7/18/2018**