OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: Ibrance® (palbociclib)

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

Drug Form/Strength: _____

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

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

***CLINICAL CRITERIA:* To receive a SIX (6) month approval, 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.**

1. Does patient have a diagnosis of advanced breast cancer that is estrogen receptor positive? ❑ Yes ❑ No
2. Is patient ≥ 18 years old or older? ❑ Yes ❑ No
3. Is medication being prescribed by an oncologist? ❑ Yes ❑ No
4. Human epidermal growth factor receptor 2 (HER2)-negative? ❑ Yes ❑ No

FDA Approved combination therapy requirements. Note: Ibrance® is NOT indicated for monotherapy.

- **Ibrance® with aromatase inhibitor:**
  - Is patient post-menopausal? ❑ Yes ❑ No
- **Ibrance with fulvestrant**:

1. Has patient failed prior endocrine therapy ❑ Yes ❑ No
2. Patient may be pre-or postmenopausal? ❑ Yes ❑ No

***Medical Necessity:* Provide clinical evidence that support the use of the requested medication.**

_____

_____

_____

***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: ~~7/26/2017; 6/23/2018;~~ **7/18/2018**