

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: 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 \geq 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 #: _____