

Ibrance® & Kisqali® Prior Authorization Request Form
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
Clinical Information: Does the patient have a confirmed diagnosis of hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Test results in chart documentation required.</i> Does the patient have advanced or metastatic (cancer has spread to other parts of the body) disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication being provided by: (Please check applicable box below) <input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____
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.*
Prescriber Signature: _____ Date: _____

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: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.