Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Palbociclib (Ibrance) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Palbociclib (Ibrance).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Prescriber specialty: □ Hematologist □ Oncologist □ Other: _____

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Indications:

□ Advanced or metastatic cancer breast cancer (HR-Positive, HER2-Negative)

□ Other: _____

6–Clinical Criteria

Initial Therapy:

1. Does the member have ALL the following?
   a) Diagnosis of advanced or metastatic breast cancer (HR-Positive, HER2-Negative)

      □ No □ Yes

   b) Hormone Receptor (HR)-Positive

      □ No □ Yes

   c) Human Epidermal Growth Factor Receptor 2 (HER2)-Negative

      □ No □ Yes

   d) Used in combination with anti-estrogen therapy (i.e. aromatase inhibitor or fulvestrant)

      □ No □ Yes

Continuation of Therapy:

2. Member does NOT show evidence of progressive disease while on therapy: □ No □ Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**