STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

PALBOCICLIB

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
PALBOCICLIB	IBRANCE	41725		GPI-10 (2153106000)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and meet **ALL** the following criteria?
   - The patient is 18 years of age or older
   - The patient is a postmenopausal female OR a male
   - The requested medication will be used in combination with an aromatase inhibitor (i.e., anastrozole, letrozole, or exemestane)
   - The patient has NOT received prior endocrine-based therapy (e.g., letrozole, anastrozole, tamoxifen, fulvestrant, exemestane)
   - The patient has NOT experienced disease progression following prior CDK inhibitor therapy

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #21 per 28 days.**
   If no, continue to #2.

2. Does the patient have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and meet **ALL** the following criteria?
   - The patient is 18 years of age or older
   - The patient has experienced disease progression following endocrine therapy (e.g., letrozole, anastrozole, tamoxifen, fulvestrant, exemestane)
   - The requested medication will be used in combination with Faslodex (fulvestrant)
   - The patient has NOT experienced disease progression following prior CDK inhibitor therapy

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #21 per 28 days.**
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

CONTINUED ON NEXT PAGE

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PALBOCICLIB

GUIDELINES FOR USE (CONTINUED)

DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **PALBOCICLIB (Ibrance)** requires the following rule(s) be met for approval:

A. You have hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer (cancer that is in the advanced stage or that has spread to other parts of the body)
B. You are 18 years of age or older
C. You meet ONE of the following:
   1. The requested medication will be used with an aromatase inhibitor (type of cancer drug such as anastrozole, letrozole, or exemestane) AND you meet ALL of the following:
      a. You are a postmenopausal female or a male
      b. You have NOT received endocrine (hormone)-based therapy (such as letrozole, anastrozole, tamoxifen, fulvestrant, exemestane)
      c. Your disease has NOT worsened after cyclin-dependent kinase (CDK) inhibitor therapy (this type of therapy is used to treat cancer by preventing the cancer cells from multiplying)
   2. The requested medication will be used in combination with Faslodex (fulvestrant) AND you meet ALL of the following:
      a. Your disease has worsened after endocrine (hormone) therapy (such as letrozole, anastrozole, tamoxifen, fulvestrant, exemestane)
      b. Your disease has NOT worsened after cyclin-dependent kinase (CDK) inhibitor therapy (this type of therapy is used to treat cancers by preventing the cancer cells from multiplying)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Ibrance.

REFERENCES

- Ibrance [Prescribing Information]. New York, NY: Pfizer Laboratories. November 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 04/01/20

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