US Family Health Plan
Prior Authorization Request Form for
Palbociclib **(Ibrance)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

1. Does the patient have advanced (metastatic) hormone receptor-positive (HR+) breast cancer?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer?	☐ Yes Proceed to Question 3	☐ No Coverage not approved
3. Is the patient a postmenopausal woman, premenopausal or perimenopausal woman, or a man?	☐ Postmenopausal woman – **Skip** to Question 5 ☐ Premenopausal or perimenopausal woman – proceed to Question 4 ☐ Man – **Skip** to Question 7	
4. Does the patient have disease progression following endocrine therapy AND is using palbociclib in combination with fulvestrant (Faslodex)?	☐ Yes Sign and date below	☐ No Proceed to Question 6
5. Does the patient have disease progression following endocrine therapy AND is using palbociclib in combination with fulvestrant (Faslodex)?	☐ Yes Sign and date below	☐ No Proceed to Question 8
6. Is the patient receiving ovarian suppression/ablation with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]), surgical bilateral oophorectomy, or ovarian irradiation?	☐ Yes **Skip** to Question 8	☐ No Coverage not approved
7. Is the patient receiving a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin])?	☐ Yes Proceed to Question 8	☐ No Coverage not approved
8. Will Ibrance be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[14 December 2018]