US Family Health Plan
Prior Authorization Request Form for
abemaciclib **(Verzenio)**

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 a diagnosis of hormone receptor positive (HR+), HER2 negative advanced or metastatic breast cancer?	☐ Yes Proceed to question **2**	☐ No Proceed to question **7**
2. Has the patient's breast cancer progressed during or after endocrine therapy?	☐ Yes Proceed to question **3**	☐ No Proceed to question **6**
3. Is the patient postmenopausal and will use Verzenio in combination with fulvestrant?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Is the patient premenopausal or perimenopausal and is receiving ovarian suppression with a GnRH agonist AND Verzenio will beused in combination with fulvestrant?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Will Verzenio be used as monotherapy and the patient has had prior chemotherapy for treatment of metastatic breast cancer?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**
6. Is the patient postmenopausal and Verzenio will be used in combination with an aromatase inhibitor, such as anastrozole or letrozole, as initial endocrine based therapy?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**

7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** 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 August 2019]