US Family Health Plan
Prior Authorization Request Form for
ribociclib (Kisqali) and ribociclib/letrozole (Kisqali Femara Co-Pack)

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 855-273-5735

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**

NOTE: Medical documentation may be requested or your request could be denied.

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. Is the requested medication prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient currently taking another cyclin-dependent kinase inhibitor?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the provider aware and has informed the patient of the risks of neutropenia and interstitial lung disease?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the provider aware and has informed the patient of the risk of QT prolongation and hepatobiliary toxicity?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have advanced or metastatic hormone receptor (HR(+))/HER2(-) breast cancer?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**

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8. What is the patient's gender?	☐ Female Proceed to question **9**	☐ Male Proceed to question **21**
9. Will the requested medication be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole?	☐ Yes Proceed to question **12**	☐ No Proceed to question **10**
10. Will the requested medication be used as first- line or later-line endocrine therapy in combination with fulvestrant?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. What is the patient's gender?	☐ Female Proceed to question **12**	☐ Male Proceed to question **21**
12. Is the patient of childbearing potential?	☐ Yes Proceed to question **13**	☐ No Proceed to question **17**
13. Does the patient agree to use effective contraception during treatment and for at least 3 weeks after cessation of therapy?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient avoid breastfeeding during treatment and for at least 3 weeks after the cessation of treatment?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
17. Is the patient a premenopausal or perimenopausal woman?	☐ Yes Proceed to question **18**	☐ No Proceed to question **19**
18. Is the patient receiving ovarian suppression/ablation with a luteinizing hormone-releasing hormone (LHRH) agonist (for example, Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin]), surgical bilateral oophorectomy, or ovarian irradiation?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. What is the requested medication?	☐ Kisqali **Sign and date below**	☐ Kisqali Femara Proceed to question **20**
20. Has the patient been informed of the risk of infertility from letrozole?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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21. Has the patient been informed of the risk of infertility?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the patient of childbearing potential?	☐ Yes Proceed to question **23**	☐ No **Sign and date below**
23. Does the patient agree to use effective contraception during treatment and for at least 3 weeks after cessation of therapy?	☐ 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 _____

[16 March 2022]