SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Kisqali® Femara® Co-Pack (Ribociclib/Letrozole) and Kisqali® (Ribociclib) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Drug Name:_____ Strength:_____ Pharmacy billing (NDC:_____)

Daily Dose:_____ Refill Number:_____ Start Date (or date of next dose):_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Diagnosis of advanced or metastatic breast cancer? Yes____ No____
2. If answer is 'no' from previous question, please indicate diagnosis:_____
3. Is this being used for first line use? Yes____ No____
4. Please indicate requested information:
   - ❑ Negative expression of Human Epidermal Receptor Type 2 (HER2)
   - ❑ Patient is postmenopausal
   - ❑ Estrogen receptor (ER)-positive
5. Will Kisqali® be used in combination with an aromatase inhibitor? Yes____ No____
6. Will Kisqali® be used in combination with fulvestrant? Yes____ No____
   b. If answer is 'yes' from previous question, is this being used as initial endocrine based therapy or following disease progression on endocrine therapy? Yes____ No____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does patient have any evidence of progressive disease while on ribociclib? Yes____ No____
3. Has the member experienced any adverse drug reactions related to ribociclib therapy? Yes____ No____

   *If yes, please specify adverse reactions:*_____

_____

Additional Information:_____

_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*