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#:*** _____

Prescriber NPI: _____ ***Prescriber Name:*** _____ ***Specialty:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Start Date:*** _____

Pharmacy Section

Pharmacy NPI: _____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:*** _____

Drug Name: _____ ***Strength:*** _____ ***Daily Dose:*** _____ ***Refill Number:*** _____

NDC: _____

Prescriber Section

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. If request is for Kisqali® (ribociclib), please provide the following information:
   A. Patient-specific, clinically significant reason why the member cannot use the co-packaged formulation with letrozole (Kisqali® Femara® Co-Pack):_____
   _____
   B. Will Kisqali® be used in combination with an aromatase inhibitor? Yes____ No____

Additional Information:_____
_____

For Continued Authorization:

1. Does patient have any evidence of progressive disease while on ribociclib? Yes____ No____
2. Has the member experienced any adverse drug reactions related to ribociclib therapy?
   Yes____ No____
   *If yes, please specify adverse reactions:*_____

Additional Information:_____
_____

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

Prescriber Signature: _____ **Date:** _____

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.*