

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Pharmacy billing (NDC: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_  
Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

**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 (Initial approval will be for the duration of 6 months):**

1. Please indicate diagnosis and information:

Breast Cancer

A. Advanced or metastatic breast cancer? Yes \_\_\_ No \_\_\_

B. Progressed after endocrine therapy? Yes \_\_\_ No \_\_\_

C. Hormone receptor (HR)-positive? Yes \_\_\_ No \_\_\_

D. Human epidermal growth factor receptor 2 (HER2)-negative? Yes \_\_\_ No \_\_\_

E. Will abemaciclib be used in combination with fulvestrant with disease progression following endocrine therapy in advanced or metastatic breast cancer? Yes \_\_\_ No \_\_\_

F. Will abemaciclib be used as monotherapy for disease progression following endocrine therapy and prior chemotherapy in metastatic breast cancer? Yes \_\_\_ No \_\_\_

Other, please provide diagnosis: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on abemaciclib? Yes \_\_\_ No \_\_\_

3. Has member experienced adverse drug reactions related to abemaciclib therapy? Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

**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:

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

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