Prior Authorization Request Form for
Palbociclib (Ibrance)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 advanced (metastatic) hormone receptor-positive (HR+) breast cancer?	☐ Yes Proceed to question **2**	☐ No Proceed to question **9**
2. Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer?	☐ Yes Proceed to Question **3**	☐ No Proceed to question **9**
3. Is the patient a postmenopausal woman, premenopausal or perimenopausal woman, or a man?	☐ Postmenopausal woman – **Skip** to Question **5** ☐ Premenopausal or perimenopausal woman – proceed to Question **4** ☐ Man – **Skip** to Question **7**	
4. Does the patient have disease progression following endocrine therapy AND is using palbociclib in combination with fulvestrant (Faslodex)?	☐ Yes **Sign and date below**	☐ No Proceed to Question **6**
5. Does the patient have disease progression following endocrine therapy AND is using palbociclib in combination with fulvestrant (Faslodex)?	☐ Yes **Sign and date below**	☐ No Proceed to Question **8**
6. Is the patient receiving ovarian suppression/ablation with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]), surgical bilateral oophorectomy, or ovarian irradiation?	☐ Yes **Skip** to Question **8**	☐ No Proceed to question **9**
7. Is the patient receiving a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin])?	☐ Yes Proceed to Question **8**	☐ No Proceed to question **9**
8. Will Ibrance be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole?	☐ Yes **Sign and date below**	☐ No Proceed to question **9**

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9. Please provide the diagnosis.	_____ Proceed to question **10**	
10. 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]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: