Prior Authorization Request Form for
ribociclib (Kisqali)

USFHP Pharmacy Prior Authorization Form

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

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) estrogen receptor-positive (ER+) disease?	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer?	☐ Yes Proceed to question **3**	☐ No Proceed to question **4**
3. Is the patient a postmenopausal woman and Kisqali will be used as first-line ENDOCRINE THERAPY in combination with an aromatase inhibitor?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Please provide the diagnosis.	_____ Proceed to question **5**	
5. 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: