TRICARE Prior Authorization Request Form for
abemaciclib **(Verzenio)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

Fax Completed Form and Applicable Progress Notes to
(410) 424 24-4037

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.

Please Note: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

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. Is the requested medication prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient currently taking another cyclin-dependent kinase inhibitor?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the provider aware and has informed the patient of the risks of neutropenia and interstitial lung disease?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the provider aware and has informed the patient of the risk of venous thromboembolism, diarrhea, and hepatotoxicity?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have hormone receptor HR(+)/HER2(-), node(+) early breast cancer at high risk of recurrence as determined by an FDA approved test?	☐ Yes Proceed to question **9**	☐ No Proceed to question **6**
6. Does the patient have advanced or metastatic hormone receptor (HR(+))/HER2(-) breast cancer?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Please provide the diagnosis.	_____ Proceed to question **8**	

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8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
9. What is the patient's gender?	☐ Female Proceed to question **10**	☐ Male Proceed to question **21**
10. Will the requested medication be used as first-line endocrine therapy in combination with anastrozole, exemestane, or letrozole?	☐ Yes Proceed to question **14**	☐ No Proceed to question **11**
11. Will the requested medication be used as first-line or later-line endocrine therapy in combination with fulvestrant?	☐ Yes Proceed to question **14**	☐ No Proceed to question **12**
12. Will the requested medication be used as monotherapy following metastatic progression on chemotherapy?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
13. What is the patient's gender?	☐ Female Proceed to question **14**	☐ Male Proceed to question **21**
14. Is the patient of childbearing potential?	☐ Yes Proceed to question **15**	☐ No Proceed to question **19**
15. Does the patient agree to use effective contraception during treatment and for at least 3 weeks after cessation of therapy?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the patient avoid breastfeeding during treatment and for at least 3 weeks after the cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
19. Is the patient a premenopausal or perimenopausal woman?	☐ Yes Proceed to question **20**	☐ No **Sign and date below**
20. Is the patient receiving ovarian suppression/ablation with a luteinizing hormone-releasing hormone (LHRH) agonist (for example, Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin]), surgical bilateral oophorectomy, or ovarian irradiation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

21. Has the patient been informed of the risk of infertility?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the patient of childbearing potential?	☐ Yes Proceed to question **23**	☐ No **Sign and date below**
23. Does the patient agree to use effective contraception during treatment and for at least 3 months after cessation of therapy?	☐ 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 _____

[27 September 2023]

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