PARAMOUNT
Affiliate of ProMedica

Criteria: P0270
Approved: 9/2019
Verified: 9/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Advantage and Paramount Commercial Members Only

VERZENIO

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Verzenio.

Drug Name (select from list of drugs shown)

Verzenio (abemaciclib)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of advanced or metastatic breast cancer? Y N
[If no, no further questions.]

2. Does the patient have hormone receptor (HR)-positive breast cancer? Y N
[If no, no further questions.]

3. Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? Y N
[If no, no further question.]

4. Will the requested drug be used in combination with fulvestrant? Y N
[If no, skip to question 6.]

5. Did the patient experience disease progression following endocrine therapy? [No further questions.]	Y N
6. Will the requested drug be used as a single agent? [If no, skip to question 9.]	Y N
7. Did the patient experience disease progression following endocrine therapy? [If no, no further questions.]	Y N
8. Did the patient experience disease progression following prior chemotherapy in the metastatic setting? [No further questions.]	Y N
9. Will the requested drug be used in combination with an aromatase inhibitor as initial endocrine-based therapy? [If no, no further questions.]	Y N
10. Is the patient post-menopausal?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date