OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Verzenio® (Abemaciclib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Dosing 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:
   - ☐ **Advanced or Metastatic Breast Cancer**
     - A. Is disease hormone receptor (HR)-positive? Yes☐ No☐
     - B. Is disease human epidermal growth factor receptor 2 (HER2)-negative? Yes☐ No☐
       - i. Will abemaciclib be used in combination with an aromatase inhibitor as initial endocrine-based therapy for postmenopausal women? Yes☐ No☐
       - ii. Will abemaciclib be used in combination with fluvestrant with disease progression following endocrine therapy? Yes☐ No☐
       - iii. Will abemaciclib be used as monotherapy for disease progression following endocrine therapy and prior chemotherapy? Yes☐ No☐
   - ☐ **Early-Stage Breast Cancer**
     - A. Is disease HR-positive? Yes☐ No☐
     - B. Is disease HER2-negative? Yes☐ No☐
     - C. Is disease node-positive with high risk for recurrence? Yes☐ No☐
     - D. Will abemaciclib be used as adjuvant treatment in combination with endocrine therapy? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, 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. *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