



**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ribociclib (Kisqali)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: <http://www.providers.kaiserpermanente.org/mas/formulary.html>

**Covered Indications:**

- Breast Cancer

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Prescriber Information**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?

Initial therapy

Continuing therapy, State date: \_\_\_\_\_

2. Indicate the patient’s diagnosis for the requested medication: \_\_\_\_\_

**Breast Cancer:**

- 1. Is the treatment for recurrent or metastatic ER/PR+, HER2- breast cancer in patients who have a contraindication or intolerance to palbociclib (but have not experienced cancer progression on prior CDK4/6 inhibitor therapy)?  
 No  Yes

**For continuation of therapy, please respond to additional questions below.**

- 1. Does the member show evidence of progressive disease while on therapy?  
 No  Yes

**6 – Prescriber Sign-Off**

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:**

\_\_\_\_\_

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility