



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Abemaciclib (Verzenio) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 12 months; Continuation- 12 months

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Abemaciclib (Verzenio)**. 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:**

- HR(+), HER2(-), Metastatic 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: \_\_\_\_\_

**HR(+), HER2(-), Metastatic Breast Cancer:**

1. Is the treatment for a member with HR(+), HER2(-), metastatic breast cancer and had a contraindication or intolerance to palbociclib?
- ☐ 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:**

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