Ibrance

Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________
Request Initiated For: _______________________

1. What is the diagnosis?
   ❑ Breast cancer
   ❑ Retroperitoneal liposarcoma
   ❑ Other ____
2. What is the ICD-10 code? _____________

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

3. What is the patient's hormone receptor (HR) status?
   ❑ Positive ❑ Negative ❑ Unknown
4. What is the patient's human epidermal growth factor receptor 2 (HER2) status?
   ❑ Positive ❑ Negative ❑ Unknown
5. What is the prescribed regimen?
   ❑ Ibrance + aromatase inhibitor (eg, anastrozole [Arimidex], exemestane [Aromasin], letrozole [Femara])
   ❑ Ibrance + fulvestrant (Faslodex), *no further questions*
   ❑ Other ____
6. Is the patient postmenopausal? ❑ Yes ❑ No

Section B: Retroperitoneal Liposarcoma

7. What is the histology?
   ❑ Well-differentiated ❑ Dedifferentiated ❑ Myxoid ❑ Pleomorphic ❑ Other _________________________

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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