

State of Oklahoma SoonerCare

Member Name:	Health Care Authority	lbrance [®] (Palbociclib)	Prior Authorization Form		
Drug Information Pharmacy billing (NDC:) Start Date (or date of next dose):		Date of Birth:	Member ID#:		
Dose: Regimen: Billing Provider Information Provider NPI: Provider Name: Provider Phone: Provider Fax: Prescriber Information Prescriber Information Prescriber Information Prescriber Information Prescriber Name: Prescriber Phone: Prescriber Fax: Specialty: Criteria For Initial Authorization (Initial approval will be for the duration of 6 months): Please indicate the diagnosis and information: Breast Cancer A. Is diagnosis advanced, metastatic disease? Yes No B. Is disease hormone receptor positive? Yes No C. Is disease hormone receptor positive? Yes No D. Will patbociclib be used in combination with an aromatase inhibitor for a postmenopausal female? Yes No F. Will patbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male? Yes No F. Will patbociclib be used in combination with an aromatase inhibitor or fulvestrant for a male? Yes No F. Will palbociclib be used in combination with an aromatase inhibitor or f					
Billing Provider Information Provider NPI: Provider Name: Provider Phone: Prescriber Information Prescriber Information Prescriber NPI: Prescriber Name: Prescriber Fax: Specialty:					
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 Does patient have any evidence of progressive disease while on palbociclib (when used for metastatic disease only)? Yes No? Has the member experienced any adverse drug reactions related to palbociclib therapy? Yes No? Yes No? If yes, please specify adverse reactions: 	 C. Is disease hormone in D. Will palbociclib be us female? Yes No E. Will palbociclib be us following endocrine t F. Will palbociclib be us Yes No If answer is none of the set of	receptor positive? Yes No ed in combination with an aromata bed in combination with fulvestrant herapy? Yes No ed in combination with an aromata	ase inhibitor for a postmenopausal for a female with disease progression ase inhibitor or fulvestrant for a male?		
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YesNo If yes, please specify adverse reactions:	metastatic disease only)? Yes No				
If yes, please specify adverse reactions:		ced any adverse drug reactions rel	iated to palbociclib therapy?		
dditional Information:	lf yes, please specify a	dverse reactions:			
	Additional Information:				

Prescriber Signature:

I certify that the indicated treatment is medically necessary and all information is true and correct to the *best of my knowledge.* Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this

Date:

form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.
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