BlueCross BlueShield
Federal Employee Program

IBRANCE
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Ibrance (palbociclib)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Ibrance for at least **6 months** continuously excluding samples? ***Please select answer below:***

❑**NO** - this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Advanced breast cancer **OR** ❑Metastatic breast cancer

i. Does the patient have a PIK3CA-mutation as detected by an FDA approved test? ***Please select answer below:***

❑**Yes**

1) Is the breast cancer endocrine-resistant? ❑Yes ❑No
2) Has the patient experienced recurrence on or after completing adjuvant endocrine therapy? ❑Yes ❑No
3) Will Ibrance be used in combination with inavolisib (Itovebi) and fulvestrant (Faslodex)? ❑Yes ❑No

❑**No**

1) Will Ibrance be used in combination with an aromatase inhibitor or fulvestrant (Faslodex)? ❑Yes ❑No

ii. Is the patient hormone receptor (HR) positive? ❑Yes ❑No

iii. Is the patient human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No

iv. **MALE Patient**: Will the patient be on concomitant therapy for suppression of testicular steroidogenesis? ❑Yes ❑No

❑Well-differentiated / dedifferentiated liposarcoma (WD-DDLS)

❑Other diagnosis ***(please specify):*** _____

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Advanced breast cancer **OR** ❑Metastatic breast cancer

i. Does the patient have a PIK3CA-mutation? ***Please select answer below:***

❑**Yes**

1) Will Ibrance be used in combination with inavolisib (Itovebi) and fulvestrant (Faslodex)? ❑Yes ❑No

❑**No**

1) Will Ibrance be used in combination with an aromatase inhibitor or fulvestrant (Faslodex)? ❑Yes ❑No

ii. **MALE Patient**: Will the patient be on concomitant therapy for suppression of testicular steroidogenesis? ❑Yes ❑No

❑Well-differentiated / dedifferentiated liposarcoma (WD-DDLS)

❑Other diagnosis ***(please specify):*** _____

b. Has the patient experienced disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No

