BlueCross BlueShield Federal Employee Program

KISQALI
PRIOR APPROVAL REQUEST

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

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.

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

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

Please select medication: ❑**Kisqali (ribociclib)** ❑**Kisqali Femara Co-Pack (ribociclib & letrozole)**

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

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

1. Does the prescriber agree to treat with a luteinizing hormone-releasing hormone (LNRH) agonist if clinically indicated? ❑Yes ❑No
2. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

a. Does the prescriber agree to monitor liver function tests (LFTs), electrocardiograms (ECGs), complete blood count (CBC), and electrolytes prior to initiation of treatment and before each cycle as clinically indicated? ❑Yes ❑No

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

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

d. What is the patient diagnosis? ***Please select answer below:***

❑Advanced or metastatic breast cancer

i. **Kisqali (ribociclib) request:** Will this medication be used in combination with Faslodex (fulvestrant)? ***Please select answer below:***

❑**YES -** will this medication be used as initial endocrine-based therapy or following disease progression on endocrine therapy? ❑Yes* ❑No

❑**NO -** will this medication be used in combination with an aromatase inhibitor? ❑Yes* ❑No

**If YES*, will this medication be used as initial endocrine-based therapy? ❑Yes ❑No

ii. **Kisqali Femara Co-Pack (ribociclib & letrozole) request:** Will this medication be used as initial endocrine-based therapy? ❑Yes ❑No

❑Early breast cancer

i. Does the patient have stage II or III early breast cancer at high risk of recurrence? ❑Yes ❑No

ii. Will this medication be used for adjuvant treatment? ❑Yes ❑No

iii. **Kisqali (ribociclib) request:** Will this medication be used in combination with an aromatase inhibitor? ❑Yes ❑No

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

a. Does the prescriber agree to monitor liver function tests (LFTs), electrocardiograms (ECGs), complete blood count (CBC), and electrolytes before each cycle as clinically indicated? ❑Yes ❑No

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

c. What is the patient diagnosis? ***Please select answer below:***

❑Advanced or metastatic breast cancer

i. **Kisqali (ribociclib) request:** Will this medication be used in combination with Faslodex (fulvestrant)? ❑Yes ❑No*

**If NO*, will this medication be used in combination with an aromatase inhibitor? ❑Yes ❑No

❑Stage II or III breast cancer

i. **Kisqali (ribociclib) request:** Will this medication be used in combination with an aromatase inhibitor? ❑Yes ❑No

