BlueCross BlueShield
Federal Employee Program

VERZENIO
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					

Verzenio (abemaciclib)

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

Please select strength and indicate quantity:

❑**50mg**	**quantity _____ per 84 days**	❑**150mg**	**quantity _____ per 84 days**
❑**100mg**	**quantity _____ per 84 days**	❑**200mg**	**quantity _____ per 84 days**

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

1. Has the patient been on Verzenio continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

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

3. What is the patient's diagnosis?
   ❑Advanced breast cancer **OR** ❑Metastatic breast cancer
   a. Is the patient hormone receptor (HR) positive? ❑Yes* ❑No
   If YES, is the patient human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No
   b. Will Verzenio be used as monotherapy? ***Please select answer below:***
   ❑**Yes**: Has the patient experienced disease progression following endocrine therapy and prior chemotherapy in the metastatic setting? ❑Yes ❑No
   ❑**No**: Will Verzenio be used in combination with an aromatase inhibitor as initial endocrine-based therapy? ❑Yes ❑No*
   If NO, has the patient experienced disease progression following endocrine therapy? ❑Yes* ❑No
   If YES, will Verzenio be used in combination with fulvestrant (Faslodex)? ❑Yes ❑No

   ❑Early breast cancer
   a. Is the patient hormone receptor (HR) positive? ❑Yes* ❑No
   If YES, please answer the following questions:
   i. Is the patient human epidermal growth factor receptor 2 (HER2)-negative? ❑Yes ❑No
   ii. Is the patient node-positive? ❑Yes ❑No
   b. Will Verzenio be used in combination with aromatase inhibitor or tamoxifen? ❑Yes ❑No

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

4. Does the prescriber agree to monitor liver function tests (LFTs), and complete blood count (CBCs) prior to initiation of treatment and each month as clinically indicated? ❑Yes ❑No

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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					

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

1. Has the patient been on Verzenio continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

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

3. What is the patient's diagnosis?
   ❑Advanced breast cancer **OR** ❑Metastatic breast cancer
      a. Will Verzenio be used as monotherapy? ❑Yes ❑No
      b. Will Verzenio be used in combination with an aromatase inhibitor? ❑Yes ❑No
      c. Will Verzenio be used in combination with fulvestrant (Faslodex)? ❑Yes ❑No
   ❑Early breast cancer
      a. Will Verzenio be used in combination with an aromatase inhibitor or tamoxifen? ❑Yes ❑No
   ❑Other diagnosis ***(please specify):*** _____

4. Has the patient experienced disease progression or unacceptable toxicity while on Verzenio? ❑Yes ❑No

5. Does the prescriber agree to monitor liver function test (LFTs), and complete blood count (CBCs) each month as clinically indicated? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Verzenio – FEP MD Fax Form Revised 9/12/2023