**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Verzenio™ Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Breast cancer

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical Information:**

Does the patient have advanced or metastatic breast cancer? ❑ **Yes** ❑ **No**

Does the patient have hormone-receptor (HR)-positive disease? ❑ **Yes** ❑ **No**

Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease? ❑ **Yes** ❑ **No**

Is the patient a postmenopausal woman? ❑ **Yes** ❑ **No**

Will Verzenio be used in combination with an aromatase inhibitor (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole])? ❑ **Yes** ❑ **No**

Will Verzenio be used in combination with Faslodex (fulvestrant)? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression following endocrine therapy? ❑ **Yes** ❑ **No**

Will Verzenio be used as monotherapy? ❑ **Yes** ❑ **No**

Has the patient received at least one prior chemotherapy regimen? ❑ **Yes** ❑ **No**

Is Verzenio prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

**Reauthorization:**

Does the patient show evidence of progressive disease while on Verzenio therapy? ❑ **Yes** ❑ **No**

**Quantity Limit Requests:**

What is the quantity requested per DAY? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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