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

Ibrance® Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Breast cancer
❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Clinical Information:

Is Ibrance prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Ibrance therapy? ❑ **Yes** ❑ **No**
Has the patient used Ibrance within the past 120 days? ❑ **Yes** ❑ **No**
Select if the patient has one of the following:
- ❑ Locally advanced disease
- ❑ Metastatic disease
- ❑ Recurrent disease
- ❑ Stage IV disease

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 female? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression following endocrine therapy? ❑ **Yes** ❑ **No**
Select if Ibrance will be used in combination with the following therapies:
- ❑ An aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)
- ❑ Faslodex (fulvestrant)

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Ibrance_CMS_2019Jan-W