**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

# Kisqali® & Kisqali® Femara® 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** | 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 disease? ❑ **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**
Select the patient's menopausal status:
❑ Pre/perimenopausal ❑ Postmenopausal
Is the requested medication prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**
Has the patient used the requested medication within the past 120 days? ❑ **Yes** ❑ **No**
**For Kisqali requests:**
Will Kisqali be used in combination with an aromatase inhibitor [e.g., Femara (letrozole)]? ❑ **Yes** ❑ **No**
Will Kisqali be used in combination with Faslodex (fulvestrant)? ❑ **Yes** ❑ **No**
**For Kisqali Femara Dose Pack requests:** Does the patient have trial and failure, contraindication, or intolerance to Kisqali and Femara (letrozole), used concomitantly? ❑ **Yes** ❑ **No**

**Quantity Limit:**
What is the quantity requested per MONTH? ________
**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
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: ________________________________________
❑ 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.
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.

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