State of Oklahoma
SoonerCare
Kisqali® Femara® Co-Pack (ribociclib/letrozole) & Kisqali® (ribociclib)
Prior Authorization Form

Member Name:______________________ **Date of Birth:**____________ **Member ID#:**________________

Drug Information

Pharmacy Billing (NDC:____________________**) Start Date (or date of next dose):**________________

Dose:_________________________________ **Regimen:**___________________________________

Pharmacy Information

Pharmacy NPI:___________________________ **Pharmacy Name:**_____________________________

Pharmacy Phone:________________________ **Pharmacy Fax:**________________________________

Prescriber Information

Prescriber NPI:____________________ **Prescriber Name:**_____________________________________

Prescriber Phone:______________ **Prescriber Fax:**_________________ **Specialty:**________________

Criteria

For Initial Authorization:

1. Is member hormone receptor positive? Yes☐ No☐
2. Is member human epidermal receptor type 2 (HER2)-negative? Yes☐ No☐
3. Please indicate the diagnosis and how Kisqali® will be used:
   - ☐ Stage II or III early breast cancer at high risk for recurrence as adjuvant therapy
   - ☐ Advanced or metastatic breast cancer as initial therapy
   - ☐ Advanced or metastatic breast cancer as initial endocrine-based therapy or following disease progression on endocrine therapy
   - ☐ Other: ____
4. Will Kisqali® be used in combination with an aromatase inhibitor? Yes☐ No☐
5. Will Kisqali® be used in combination with fluvestrant? Yes☐ No☐

Additional Information: ____

For Continued Authorization:

1. Date of last dose: ____________________
2. Does patient have any evidence of progressive disease while on Kisqali®? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to Kisqali® therapy? Yes☐ No☐
   If yes, please specify adverse reactions: ____

Prescriber Signature:_______________________________ **Date:**____________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*