

Prescriber Criteria Form

Ibrance 2026 PA Fax 1236-A v3 010126.docx

Ibrance (palbociclib)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ibrance (palbociclib).

Drug Name:
Ibrance (palbociclib)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of breast cancer? [If no, then skip to question 12.]	Yes	No
2	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes	No
3	Does the patient have hormone receptor (HR)-positive breast cancer? [If no, then no further questions.]	Yes	No
4	Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? [If no, then no further questions.]	Yes	No
5	Will the requested drug be used in combination with inavolisib and fulvestrant? [If no, then skip to question 8.]	Yes	No
6	Is the patient endocrine resistant? [If no, then no further questions.]	Yes	No
7	Does the patient have PIK3CA mutation? [No further questions.]	Yes	No
8	Will the requested drug be used in combination with an aromatase inhibitor? [If yes, then skip to question 10.]	Yes	No

9	Will the requested drug be used in combination with fulvestrant? [If no, then no further questions.]	Yes	No
10	Has the patient experienced an intolerable adverse event to Kisqali (ribociclib)? [If yes, then no further questions.]	Yes	No
11	Does the patient have a contraindication to Kisqali (ribociclib)? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum?	Yes	No

Comments:	_____
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____	Date: _____
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