

**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.	
<b>Prescriber (or Authorized) Signature:</b> _____	<b>Date:</b> _____