Prescriber Criteria Form Kisqali-Kisqali Femara 2026 PA Fax 1638-A v1 010126.docx Kisqali (ribociclib), Kisqali Femara Co-Pack (ribociclib and letrozole) 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 Kisqali-Kisqali Femara.

Drug Name (select from list of drugs shown):

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 11.]	Yes	No
2	Does the patient have hormone receptor (HR)-positive breast cancer? [If no, then no further questions.]	Yes	No
3	Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? [If no, then no further questions.]	Yes	No
4	Is the disease stage II or stage III early breast cancer? [If no, then skip to question 7.]	Yes	No
5	Is the disease at high risk of recurrence? [If no, then no further questions.]	Yes	No
6	Will the requested drug be used in combination with an aromatase inhibitor? [No further questions.]	Yes	No
7	Is the disease advanced, recurrent, or metastatic? [If no, then no further questions.]	Yes	No
8	Will the requested drug be used in combination with an aromatase inhibitor? [If no, then skip to question 10.]	Yes	No

9	Will the requested drug be used as initial endocrine-based therapy? [No further questions.]	Yes	No
10	Will the requested drug be used in combination with fulvestrant? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of endometrial cancer? [If no, then no further questions]	Yes	No
12	Will the requested drug be used in combination with letrozole for estrogen receptor positive tumors?	Yes	No

Comments:	_____

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:**_____