Prescriber Criteria Form

Verzenio 2026 PA Fax 2343-A v2 010126.docx
Verzenio (abemaciclib)
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 Verzenio (abemaciclib).

Drug Name:
Verzenio (abemaciclib)

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 recurrent, advanced, or metastatic breast cancer? [If yes, then skip to question 3.]	Yes	No
2	Does the patient have a diagnosis of early breast cancer? [If no, then skip to question 8.]	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 endocrine therapy or as a single agent? [If no, then no further questions.]	Yes	No
6	Has the patient experienced an intolerable adverse event to Kisqali (ribociclib)? [If yes, then no further questions.]	Yes	No
7	Does the patient have a contraindication to Kisqali (ribociclib)? [No further questions.]	Yes	No

8	Does the patient have a diagnosis of endometrial cancer? [If no, then no further questions.]	Yes	No
9	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:**_____