



Please complete ALL information below and fax your request to 1-888-671-5285

### Verzenio™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

#### Member Information (required) Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

#### Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

#### Clinical Information (required)

**Select the diagnosis below:**

Breast cancer

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Does the patient have advanced or metastatic breast cancer?  Yes  No

Does the patient have hormone-receptor (HR)-positive disease?  Yes  No

Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease?  Yes  No

Is the patient a postmenopausal woman?  Yes  No

Will Verzenio be used in combination with an aromatase inhibitor (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole])?  Yes  No

Will Verzenio be used in combination with Faslodex (fulvestrant)?  Yes  No

Has the patient experienced disease progression following endocrine therapy?  Yes  No

Will Verzenio be used as monotherapy?  Yes  No

Has the patient received at least one prior chemotherapy regimen?  Yes  No

Is Verzenio prescribed by or in consultation with an oncologist?  Yes  No

**Reauthorization:**

Does the patient show evidence of progressive disease while on Verzenio therapy?  Yes  No

**Quantity Limit Requests:**

What is the quantity requested per DAY? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

Titration or loading dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

Other: \_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately. Office use only: Verzenio\_FSP\_2019Mar-W