UnitedHealthcare Community Plan

Ibrance
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check all that apply)
□ Advanced or metastatic breast cancer
□ Well differentiated/dedifferentiated Liposarcoma (WD-DDLS) for Retroperitoneal Sarcomas
□ Other, list diagnosis: _____

- Is the disease hormone-receptor (HR)-positive? □ Yes □ No

- Is the disease human epidermal growth factor receptor 2 (HER2) – negative? □ Yes □ No

- Is Ibrance being used in combination with an aromatase inhibitor (e.g. anastrozole, letrozole, exemestane)?
□ **Yes** □ **No** (If yes, complete Section D above with medication information, including dose, and duration)

- Is Ibrance being used in combination with Faslodex? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, and duration)

- Does the patient have disease progression following endocrine therapy? □ Yes □ No

Continuation of Care Requests:
- Does the patient show evidence of progressive disease while on Ibrance therapy? □ Yes □ No

Physician Signature: _____ Date: _____