Prescriber Criteria Form
Kisqali-Kisqali Femara 2025 PA Fax 1638-A v1 010125.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 8.]	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 an aromatase inhibitor? [If no, then skip to question 7.]	Yes ◯	No ◯
6	Will the requested drug be used as initial endocrine-based therapy? [No further questions.]	Yes ◯	No ◯
7	Will the requested drug be used in combination with fulvestrant? [No further questions.]	Yes ◯	No ◯

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