Prescriber Criteria Form Verzenio 2024 PA Fax 2343-A v2 010124.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 no, then skip to question 9.]	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 question.]	Yes	No
4	Will the requested drug be used in combination with fulvestrant? [If yes, then no further questions.]	Yes	No
5	Will the requested drug be used in combination with an aromatase inhibitor? [If yes, then no further questions.]	Yes	No
6	Will the requested drug be used as a single agent? [If no, then no further questions.]	Yes	No
7	Did the patient experience disease progression following endocrine therapy? [If no, then no further questions.]	Yes	No

8	Did the patient experience disease progression following prior chemotherapy in the metastatic setting? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of early breast cancer and is at high risk of disease recurrence? [If no, then no further question.]	Yes	No
10	Does the patient have hormone receptor (HR)-positive breast cancer? [If no, then no further questions.]	Yes	No
11	Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? [If no, then no further questions.]	Yes	No
12	Does the patient have node-positive breast cancer? [If no, then no further questions.]	Yes	No
13	Will the requested drug be used as adjuvant treatment in combination with endocrine therapy (tamoxifen or an aromatase inhibitor)?	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:**_____