

CDK Inhibitors

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082

Date of request:			
Patient	Date of birth	Molina ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
 If yes, is there documentation demonstrating disease stability or a positive clinical response?
☐ Yes ☐ No

2. Indicate patient's diagnosis:
☐ Adjuvant therapy of early-stage (stage I-III) breast cancer (EBC)
☐ Systemic therapy of recurrent, advanced, or metastatic breast cancer
☐ Other, specify: _____

3. Indicate stage: _____

4. What is the patients hormone reception and HER2 status?
 Hormone receptor: ☐ Positive ☐ Negative
 HER2: ☐ Positive ☐ Negative

5. Is this being prescribed by or in consultation with an oncologist? ☐ Yes ☐ No

6. Will this medication be used in combination with other agents for the treatment of this diagnosis?
☐ No
☐ Yes, specify regimen: _____

7. Has patient previously progressed on, or after treatment with another CDK4/6 inhibitor (e.g., ribociclib [Kisqali], abemaciclib [Verzenio])?
☐ No
☐ Yes, explain: _____

Request for Adjuvant therapy of early-stage (stage I-III) breast cancer (EBC) answer the following:

8. Provider attests the patient has high-risk breast cancer based on which of the following? Check all that apply:
- ☐ Histopathological tests showing four or more (≥ 4) axillary lymph nodes are affected (pALN N2 or N3 disease)
 - ☐ Histopathological tests showing one to three axillary lymph nodes are affected
 - ☐ Tumor size is ≥ 5 cm
 - ☐ Histopathological grade 3 disease (G3)
 - ☐ Ki-67 score $\geq 20\%$ as determined by an FDA-approved test
 - ☐ Other. Specify: _____
9. Has the patient undergone surgical resection of the primary tumor? ☐ Yes ☐ No
10. Does the patient have a history of failure or intolerance using one of the following treatment modalities? Check all that apply.
- ☐ Radiotherapy
 - ☐ Taxane (e.g., docetaxel)
 - ☐ Anthracycline (e.g., doxorubicin) based chemotherapy

Request for Systemic therapy of recurrent, advanced, or metastatic breast cancer, answer the following:

11. Is the treatment being prescribed as a first-line systemic therapy? ☐ Yes ☐ No
If yes, please select all that apply:
- ☐ The patient is a postmenopausal female, premenopausal or perimenopausal female receiving ovarian suppression/ablation (e.g., surgical ablation, suppression with GnRH therapy [e.g., leuprolide], etc.)
 - ☐ The patient is hormone suppressed male (e.g., GnRH therapy [e.g., leuprolide] used concomitantly)
12. Is the treatment being prescribed as a second-line systemic therapy? ☐ Yes ☐ No
If yes, please select all that apply:
- ☐ The medication will be used in combination with fulvestrant (Faslodex)
 - ☐ The patient had disease progression on, or after primary endocrine therapy (as adjuvant or first-line systemic therapy)
 - ☐ The patient is a postmenopausal female, premenopausal or perimenopausal female receiving ovarian suppression/ablation (e.g., surgical ablation, suppression with GnRH therapy [e.g., leuprolide])
 - ☐ The patient is hormone suppressed male (e.g., GnRH therapy [e.g., leuprolide] used concomitantly)
13. Is the treatment being prescribed as a subsequent-line (3rd line or later) systemic therapy in metastatic (stage IV, M1) setting? ☐ Yes ☐ No
If yes, please select all that apply:

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| <input type="checkbox"/> Patient had disease progression on, or after endocrine therapy AND systemic chemotherapy (not containing a CDK 4/6 inhibitor) in the metastatic setting.
<input type="checkbox"/> The request is for abemaciclib (Verzenio) monotherapy. |
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CHART NOTES & LABS ARE REQUIRED WITH THIS REQUEST
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Prescriber signature	Prescriber specialty	Date
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