PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 9/2019
VERIFIED: 1/2022
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Verzenio

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Verzenio.

Brand Name (select from list of drugs shown)

Verzenio (abemaciclib)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

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?	Yes	No

[If no, then no further question.]

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 at high risk of 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	Does the patient have a Ki-67 score greater than or equal to 20 percent? [If no, then no further questions.]	Yes	No

14	Will the requested drug be used as adjuvant treatment in combination with endocrine therapy (tamoxifen or an aromatase inhibitor)?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date