CareSource

PHARMACY POLICY STATEMENT **Georgia Medicaid**	
DRUG NAME	Ibrance (palbociclib)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 21 caps per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ibrance (palbociclib) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

BREAST CANCER

For **initial** authorization:

1. Member must me 18 years of age or older; AND
2. Medication must be prescribed by oncologist/hematologist; AND
3. Member has hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer; AND
4. Medication is being used in combination with letrozole in postmenopausal women not previously treated with endocrine-based therapy OR with fulvestrant in women with disease progression following endocrine therapy (i.e. anastrozole, exemestane, letrozole, tamoxifen, toremifene).
5. **Dosage allowed:** Once daily taken with food for 21 days followed by 7 days off treatment.

If member meets all the requirements listed above, the medication will be approved.

CareSource considers Ibrance (palbociclib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/29/2017	New policy for Ibrance created.

References:

1. Ibrance [package insert]. New York, NY; Pfizer, Inc: March 2017.

Effective date: 09/01/2017
Revised date: 06/29/2017