USPSTF Copay Free Aromatase Inhibitor Coverage for Breast Cancer Prevention Request Form

Cleveland Clinic
Employee Health Plan Pharmacy Management
Questions? Call: 216.986.1050, option 4

Please complete this form and return via fax: 216-442-5790

Member Name: _____

Member EHP Insurance ID Number: _____ **Member DOB:** _____

Requesting Physician's Name: _____

Office Phone Number: _____ **Office Fax Number:** _____

Requesting Physician's Signature: _____ **Date:** _____

Requested Aromatase Inhibitor: _____

Strength: _____ **Quantity:** _____ **Dosage Regimen:** _____

Please answer the following questions in regards to the member (patient):

1. Gender? **Male** **Female**
2. Age ____ (Must be ≥ 35 years old)
3. Postmenopausal? **Yes** **No**
4. Personal history of breast cancer? **Yes** **No** (Copay free aromatase inhibitor is for primary breast cancer risk reduction)
5. Known carrier of mutation in BRCA1/2? **Yes** **No**
6. Personal history of ovarian, fallopian tube, or primary peritoneal cancer? **Yes** **No**
7. Personal history of pancreatic cancer? **Yes** **No**
8. Family history of a known BRCA1/2 mutation? **Yes** **No**
9. Family history of breast cancer, ovarian, fallopian tube, or primary peritoneal cancer, or pancreatic cancer, or prostate cancer (please list specific details of relationship to member and type of cancer):

Internal Use Only*: *DO NOT WRITE BELOW

Medical	Pharmacy		MDR Outcome
Approved Tier 1	Initial Determination	Provider 1st Level	Approved
Approved Tier 2	Member 1st Level	Provider 2nd Level	Denied
Denied	Member 2nd Level	External Review	Peer-to-Peer