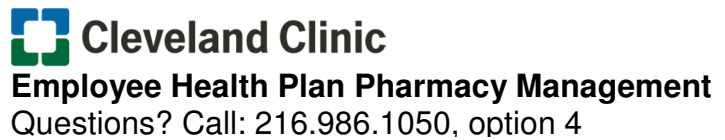


**USPSTF Copay Free
Aromatase Inhibitor
Coverage for Breast Cancer
Prevention Request Form**



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 1 st Level	Approved
Approved Tier 2	Member 1 st Level	Provider 2 nd Level	Denied
Denied	Member 2 nd Level	External Review	Peer-to-Peer

