Please complete ALL information below and fax your request to 1-888-671-5285

Zytiga® & abiraterone acetate Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Prostate cancer

❑ Other diagnosis: ______________________________________ ICD-10 Code(s): ___________________________________

Clinical Information:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Does the patient have castration resistant (chemical or surgical) prostate cancer? ❑ **Yes** ❑ **No**

Does the patient have high-risk castration-sensitive prostate cancer? ❑ **Yes** ❑ **No**

Does the patient have recurrent prostate cancer? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with prednisone? ❑ **Yes** ❑ **No**

Will Zytiga be used in combination with a gonadotropin-releasing hormone (GnRH) analog? ❑ **Yes** ❑ **No**

Has the patient received bilateral orchiectomy? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with an oncologist or urologist? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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