

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Provenge (sipuleucel-T)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Provenge intravenous suspension 250mL

Dose: _____ Start date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center

Home Infusion

Name of center: _____

Name of agency: _____

Billing options:

Physician buy and bill

Preferred Specialty Vendor

Other: _____

Priority Health Precertification Requirements:

Authorization of Provenge requires:

- Diagnosis of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer
- Eastern Cooperative Oncology Group (ECOG) performance status of 0-1
- Life expectancy greater than 6 months
- Serum prostate-specific antigen (PSA) \geq 5 ng/mL
- Two sequential rising PSA levels obtained 2–3 weeks apart or other evidence of disease progression
- Serum testosterone $<$ 50 ng/dL
- Prior use of docetaxel every 3 weeks and steroids (NCCN category 1 recommendation)
- Provenge will not be authorized for patients with any of the following:
 - Requirement for systemic corticosteroid use
 - Use of opioid analgesics for cancer-related pain
 - Visceral metastases
 - ECOG performance status \geq 2
 - Pathologic long-bone fractures
 - Spinal cord compression

