

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

Zytiga[®] (abiraterone)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Zytiga 250 mg Dose: _____ Start Date: _____

Note: Zytiga must be given with prednisone 5 mg twice daily.

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Zytiga[®] (abiraterone) requires the following information to certify:

Authorization for Zytiga requires:

- Diagnosis of hormone-refractory metastatic prostate cancer
- Prior use of a docetaxel-containing treatment regimen
- Serum prostate-specific antigen (PSA) greater than or equal to 5 ng/mL
- Two sequential rising PSA levels obtained 2 or 3 weeks apart or other evidence of disease progression
- Eastern Cooperative Oncology Group (ECOG) performance status of 0–2
- Serum testosterone less than 50 ng/dL

Zytiga will not be authorized in patients with (1) ECOG performance status greater than or equal to 3, (2) severe hepatic impairment, (3) NYHA Class III or IV heart failure, or (4) a history of adrenal or pituitary gland disorders.

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Zytiga[®] (abiraterone) requires the following information to certify:

A. What is the patient's diagnosis?

a. hormone refractory metastatic prostate cancer

b. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. What is the patient's ECOG status?

- 0: Fully active, able to carry on all pre-disease performance without restriction
- 1: Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light or sedentary nature (e.g. light house work, office work)
- 2: Ambulatory and capable of all selfcare, but unable to carry out any work activities; Up and about more than 50% of waking hours.
- 3: Capable of only limited self care; confined to bed or chair more than 50% of waking hours.
- 4: Completely disabled; cannot carry on any self care; totally confined to bed or chair.

C. Provide patient's serum PSA levels:

Date: _____ Level: _____ ng/mL

Date: _____ Level: _____ ng/mL

D. What is the patient's serum testosterone level?

Date: _____ Level: _____ ng/mL

E. Has the patient had a trial of a docetaxel given every 3 weeks with steroids for 10 courses?

Yes

No, Rationale for use: _____

F. Which of the following apply to this patient?

Reminder: Zytiga will not be authorized if any of the below criteria apply to the patient:

ECOG performance status greater than or equal to 3

Severe hepatic impairment

NYHA Class III or IV heart failure

History of adrenal or pituitary gland disorders

None of the above

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX