

# 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<sup>®</sup> (abiraterone)

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the 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:** \_\_\_\_\_

**Coverage Duration:** When authorized, Zytiga is approved for 8 months.

### PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

**Authorization for Zytiga<sup>®</sup> (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

*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.*

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**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Zytiga<sup>®</sup> (abiraterone) requires the following information to certify:

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**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) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

**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. Has the patient had a trial of a docetaxel-containing treatment regimen?**

Yes

No, Rationale for use: \_\_\_\_\_

**E. 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

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**FOR MEDICARE ONLY**

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If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1.  All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2.  The number of doses available under a dose restriction for the prescription drug:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3.  The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
  - c.  Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4.  None of the above apply

**\*\*If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**