PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Erleada™ (apalutamide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Erleada™ 60mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The annual wholesale acquisition cost for Erleada™ is more than $131,000.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of non-metastatic castration-resistant prostate cancer (NM-CRPC)
2. Eastern Cooperative Oncology Group (ECOG) performance status of 0-1
3. The patient is currently receiving gonadotropin-releasing hormone (GnRH) analog therapy or has had a bilateral orchiectomy
    - Serum testosterone is less than 50ng/dL

Erleada will not be authorized in combination with Zytiga® or Xtandi®.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Non-metastatic castration-resistant prostate cancer (NM-CRPC)

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 04/2018

Last reviewed 04/2018

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 self care, 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. Is the patient currently receiving gonadotropin-releasing hormone (GnRH) analog therapy OR has had a bilateral orchiectomy?

- ☐ Yes
- ☐ No

Rationale for not using GnRH analog/orchiectomy: _____

_____

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

Date: _____ Level: _____ ng/mL

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.

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Last reviewed 04/2018