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.

Xtandi® (enzalutamide)

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: ☒ Xtandi 40 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Oral oncology partial fill program

Each fill of Xtandi is limited to a 14 day supply at any network pharmacy. Patients are responsible for applicable deductable and copayments.

Drug cost information

The wholesale acquisition cost for each Xtandi capsule is $73.73. The annual cost of treatment with this drug is more than $106,100 each year.

Precertification Requirements

Patient must meet all of the following criteria:

1. Must be used for the treatment of castration-resistant prostate cancer
2. Eastern Cooperative Oncology Group (ECOG) performance status of 0–2
3. Serum testosterone less than 50 ng/dL

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

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.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2018

Last reviewed 11/2018

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ metastatic castration-resistant prostate cancer
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient had a documented trial with Zytiga?

- ☐ Yes
- ☐ No:

If no:

Are visceral metastases present?

- ☐ Yes
- ☐ No

Which of the following has the member been treated with?

- ☐ docetaxel
- ☐ Xtandi
- ☐ Zytiga
- ☐ None of the above

C. 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

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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