

**Priority Health Medicare prior authorization form**

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  Medicare Part B  Medicare Part D  
 This request is:  Expedited request  Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

**Yonsa<sup>®</sup>** (abiraterone)

**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:  Yonsa 125 mg tablet  
 Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose (if applicable): \_\_\_\_\_  
 Dosing frequency: \_\_\_\_\_  
 Coverage duration: 8 months

**Precertification Requirements**

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Diagnosis of metastatic castration-resistant prostate cancer (given in combination with methylprednisolone)
  - a. Eastern Cooperative Oncology Group (ECOG) performance status of 0 - 2
  - b. Serum prostate-specific antigen (PSA) greater than or equal to 5 mg/mL
  - c. Two sequential rising PSA levels obtained 2 or 3 weeks apart, or other evidence of disease progression
  - d. Must not have severe hepatic impairment; New York Heart Association (NYHA) Class III or IV heart failure; or history of adrenal or pituitary gland disorders

**Medically accepted indication**

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

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**Priority Health Precertification Documentation**

**A. What is the patient's diagnosis?**

- metastatic castration-resistant prostate cancer
- high risk castration sensitive prostate cancer
- Other – the patient's condition is: \_\_\_\_\_

**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. Provide patient's serum PSA levels:**

Date: \_\_\_\_\_ Level: \_\_\_\_\_ ng/mL

Date: \_\_\_\_\_ Level: \_\_\_\_\_ ng/mL

**D. Which of the following criteria apply to this 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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**Priority Health Medicare exception request**

**Do you believe one or more of the prior authorization requirements should be waived?**  Yes  No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would Yonsa likely be the most effective option for this patient?**

No

Yes, because: \_\_\_\_\_

**If the patient is currently using Yonsa, would changing the patient's current regimen likely result in adverse effects for the patient?**

No

Yes, because: \_\_\_\_\_

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**Additional information**

When authorized, Priority Health will cover up Zytiga for 8 months.