State of Oklahoma
SoonerCare
Zytiga®/ Yonsa® (Abiraterone) Prior Authorization Form

Member Name:_______________________ Date of Birth:_____________ Member ID#:_________________

Drug Information

Pharmacy Billing (NDC:_____________________) Start Date (or date of next dose):__________________

Dose:__________________________________ Regimen:______________________________________

Pharmacy Information

Pharmacy NPI:____________________________ Pharmacy Name:________________________________

Pharmacy Phone:_________________________ Pharmacy Fax:_________________________________

Prescriber Information

Prescriber NPI:_____________________ Prescriber Name:____

Prescriber Phone:______________ Prescriber Fax:__________________ Specialty:__________________

Criteria

For Initial Authorization:

1. Will abiraterone be used in combination with a corticosteroid? Yes____ No____
2. Please indicate the diagnosis and information:
   - ❑ **Metastatic Castration-Resistant Prostate Cancer (CRPC)**
     - A. Will abiraterone be used in combination with a gonadotropin-releasing hormone (GnRH) analog? Yes____ No_____
     - B. Does member have a prior history of bilateral orchiectomy? Yes____ No_____
   - ❑ **Metastatic Castration-Sensitive Prostate Cancer (CSPC)**
     - A. Does the member have high-risk disease? Yes____ No_____
   - ❑ **If answer is none of the above, please indicate diagnosis:**_______________________________
3. If the request is for Zytiga® 500mg tablet (or generic abiraterone 500mg tablet), please provide a patient-specific, clinically significant reason why the member cannot use generic abiraterone 250mg tablets to achieve the requested dose: ____
   ____

Additional Information:____

For Continued Authorization:

1. Date of last dose:______________________
2. Does patient have any evidence of progressive disease while on abiraterone therapy? Yes____ No____
3. Has the member experienced any adverse drug reactions related to abiraterone therapy? Yes____ No____

*If yes, please specify adverse reactions:*____

Prescriber Signature: ________________________________ Date:_____________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*