SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Xofigo® (Radium-223 Dichloride) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Diagnosis of metastatic, castration-resistant prostate cancer? Yes ☐ No ☐
2. If answer is 'no' from previous question, please indicate diagnosis: _____

Additional Information: _____

_____

3. Please indicate requested information:
   a. Does the member have symptomatic bone metastases? Yes ☐ No ☐
   b. Does the member have known visceral metastatic disease? Yes ☐ No ☐
   c. Will radium-223 (Xofigo®) be used in combination with chemotherapy? Yes ☐ No ☐
4. Please provide the following:
   a. Member's absolute neutrophil count: _____ Date taken: _____
   b. Member's platelet count: _____ Date taken: _____
   c. Member's hemoglobin: _____ Date taken: _____
   d. Member's body weight (kg): _____ Date taken: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on radium-223 dichloride therapy?
   Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to radium-223 dichloride therapy?
   Yes ☐ No ☐

If yes, please specify adverse reactions: _____

4. Please provide the following:
   a. Member's absolute neutrophil count: _____ Date taken: _____
   b. Member's platelet count: _____ Date taken: _____

Additional Information: _____

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.*