

US Family Health Plan

Prior Authorization Request Form for apalutamide (**Erleada**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire in 1 year.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Erleada	<input type="checkbox"/> Yes (subject to verification) Proceed to question 13	<input type="checkbox"/> No Proceed to question 2
2. Xtandi is the Department of Defense's preferred 2nd-Generation Antiandrogen agent. Has the patient tried Xtandi?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 3
3. Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Xtandi that is not expected to occur with Erleada?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Stop Coverage not approved
4. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Stop Coverage not approved
5. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Stop Coverage not approved
6. Does the patient have a diagnosis of NON-METASTATIC castration-resistant prostate cancer?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 9
7. Did the patient have a negative CT scan of abdomen and pelvis and/or negative bone scan?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Stop Coverage not approved

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8. Does the patient have a prostate-specific antigen doubling time (PSADT) of less than or equal to 10 months?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Stop Coverage not approved
9. Please provide the diagnosis.	_____ Proceed to question 10	
10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
11. Is this medication being prescribed in combination with a gonadotropin-releasing hormone analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 12
12. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Stop Coverage not approved
13. Does the patient continue to be free of metastases?	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No Stop Coverage not approved
14. Has the patient developed toxicities?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Proceed to question 15
15. Has the patient progressed onto subsequent therapy (such as abiraterone)?	<input type="checkbox"/> Yes Stop Coverage not approved	<input type="checkbox"/> No Sign and date below

Step I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date