US Family Health Plan
Prior Authorization Request Form for
enzalutamide **(Xtandi)**

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**

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. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ METASTATIC castration-resistant prostate cancer - Proceed to question **7** ☐ NON-METATASTIC castration-resistant prostate cancer - Proceed to question **4** ☐ Other indication - Proceed to question **5**	
4. Does the patient have a prostate-specific antigen doubling time (PSADT) of less that than or equal to 10 months?	☐ Yes Proceed to question **7**	☐ No **Stop** **Coverage not approved**
5. Please provide the diagnosis.	_____ Proceed to question **6**	

6. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**
7. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. Has the patient had bilateral orchiectomy?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**

Step 3

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

_____ _____

Prescriber Signature Date