US Family Health Plan
Prior Authorization Request Form for
Zytiga **(abiraterone)**

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. Yonsa is the Department of Defense's preferred CYP-17 Inhibitor agent. Has the patient tried Yonsa?	☐ Yes Proceed to question **3**	☐ No Proceed to question **2**
2. Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Yonsa that is not expected to occur with the requested agent?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. For which indication is the requested medication being prescribed?	☐ Metastatic castration-resistant prostate cancer (mCRPC) Proceed to question **8** ☐ Metastatic castration-sensitive prostate cancer (mCSPC) Proceed to question **8** ☐ Regional disease (TxN1M0) - Proceed to question **8** ☐ Other indication - Proceed to question **6**	

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6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving concomitant therapy with prednisone?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	☐ Yes Proceed to question **11**	☐ No Proceed to question **10**
10. Has the patient had bilateral orchiectomy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Zytiga 250 mg is the DoD's preferred strength. **Is the prescription for Zytiga 250mg OR will the prescription be changed to the 250 mg? Note:** *If the prescription is being changed to the 250 mg strength, please submit a new prescription.*	☐ Yes **Sign and date below**	☐ No Proceed to question **12**
12. Please state why the patient cannot take multiple 250 mg tablets to achieve the patient's daily dose.	**Sign and date below**	

Step 3

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

_____ _____
Prescriber Signature Date

[31 July 2019]