

US Family Health Plan

Prior Authorization Request Form for abiraterone acetate (**Zytiga**) 250mg

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 855-273-5735

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: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. For which indication is the requested medication being prescribed?	<input type="checkbox"/> Metastatic castration-resistant prostate cancer (mCRPC) - Proceed to question 6 <input type="checkbox"/> Metastatic castration-sensitive prostate cancer (mCSPC) - Proceed to question 6 <input type="checkbox"/> Regional disease (TxN1M0) - Proceed to question 6 <input type="checkbox"/> Other indication - Proceed to question 4	
4. Please provide the diagnosis.	_____ Proceed to question 5	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved

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6. Is the patient receiving concomitant therapy with prednisone?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 8
8. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[27 March 2020]