USFHP Prior Authorization Request Form for
abiraterone acetate (Zytiga) 250mg and 500mg

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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 requested medication being prescribed by a hematologist, oncologist or urologist?	☐ Yes **Sign and date below**	☐ No Proceed to question **2**
2. Is the requested medication being in consultation with a hematologist, oncologist or urologist?	☐ 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 patient receiving concomitant therapy with prednisone?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**

6. Has the patient had bilateral orchiectomy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. For which indication is the requested medication being prescribed?	☐ Metastatic castration-resistant prostate cancer (mCRPC) - **Sign and date below** ☐ Metastatic castration-sensitive prostate cancer (mCSPC) - **Sign and date below** ☐ Regional disease (TxN1M0) - **Sign and date below** ☐ Other indication - Proceed to question **8**	
8. The diagnosis IS NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **To facilitate approval, please list the diagnosis, guideline version, and page number:**	_____ **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