{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ Frequency: _____ Strength: _____
Route of Administration: _____ Expected Length of Therapy: _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed product?
   ❑ Zytiga 250mg ❑ Zytiga 500mg ❑ abiraterone 250mg ❑ abiraterone 500mg
2. What is the patient's diagnosis?
   ❑ Prostate cancer
   ❑ Salivary gland tumor
   ❑ Other _____
3. What is the ICD-10 code? _____

Complete the following questions if Zytiga is being prescribed. If abiraterone is being prescribed, skip to #10.

4. The preferred products for your patient's health plan are abiraterone, bicalutamide, Erleada, Xtandi, and Yonsa. Can the patient's treatment be switched to a preferred product?
   ❑ Yes - specify:_____
   ❑ No - Continue request for Zytiga
5. Has the patient failed treatment with abiraterone (generic) due to a documented intolerable adverse event? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)? ***ACTION REQUIRED: If No, attach supporting chart note(s).*** ❑ Yes ❑ No
7. Is this a request for the treatment of metastatic castration sensitive prostate cancer (mCSPC)?
   ❑ Yes ❑ No *If No, skip to #9*
8. Did the patient experience disease progression or does the patient have a documented intolerable adverse event or contraindication to treatment with at least 2 of the other preferred products (bicalutamide, Erleada, Xtandi)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #10.*** ❑ Yes ❑ No
9. Did the patient experience disease progression or does the patient have a documented intolerable adverse event or contraindication to treatment with at least 2 of the other preferred products (bicalutamide, Erleada, Xtandi, Yonsa)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

10. Will the requested medication be used in combination with either of the following classes of medication?
    - ❑ Second-generation oral anti-androgen (e.g., apalutamide [Erleada])
    - ❑ Oral androgen metabolism inhibitor (e.g., fine-particle abiraterone acetate [Yonsa])
    - ❑ No
11. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #13*
12. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
    ❑ Yes ❑ No *No further questions.*
13. What is the clinical setting in which the requested medication will be used?
    - ❑ Recurrent disease
    - ❑ Metastatic disease
    - ❑ Non-metastatic node positive disease
    - ❑ Non-metastatic high-risk disease
    - ❑ Non-metastatic very-high-risk disease
    - ❑ Non-metastatic prostate-specific antigen (PSA) persistence/recurrence after radical prostatectomy
    - ❑ Other_____

Complete the following section based on patient's diagnosis if applicable.

Prostate Cancer

1. Has the patient had a bilateral orchiectomy? *If Yes, no further questions.* ❑ Yes ❑ No
2. Will the requested medication be used in combination with a GnRH agonist or degarelix? ❑ Yes ❑ No

Salivary Gland Tumor

1. Will the requested medication be used as a single agent? ❑ Yes ❑ No
2. Is the tumor androgen receptor positive? ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date