



**BlueCross  
BlueShield**

Federal Employee Program

**ZYTIGA  
PRIOR APPROVAL REQUEST**

Send completed form to:  
Service Benefit Plan  
Prior Approval  
P.O. Box 52080 MC 139  
Phoenix, AZ 85072-2080  
Attn: Clinical Services  
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**For Standard Option patients GENERIC Zytiga (abiraterone acetate) is a preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to generic Zytiga will be eligible for 2 copays at no cost in the benefit year.**

**Zytiga**  
(abiraterone acetate)

**NOTE:** Form must be completed in its **entirety** for processing

<b>Please select strength:</b>	<input type="checkbox"/> 250 mg	<input type="checkbox"/> 500 mg
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**\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ☐ Brand ☐ Generic

How many tablets will the patient need for a 90 day supply? \_\_\_\_\_ tablet(s) per 90 days

1. **BRAND Zytiga Request (Standard Option Patient):** Would you like to switch the patient to the preferred product, abiraterone acetate (**GENERIC Zytiga**)? ☐ Yes, switch to abiraterone acetate (**generic Zytiga**) ☐ No\*

**\*If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to abiraterone acetate (**generic Zytiga**)? **Please select answer below:**

☐ Yes (please specify): \_\_\_\_\_

☐ No: Is there a clinical reason for not trying abiraterone acetate (**generic Zytiga**)? ☐ Yes\* ☐ No

**\*If YES**, please specify: \_\_\_\_\_

2. **GENERIC Zytiga Request (Standard Option Patient):** Is abiraterone acetate (**generic Zytiga**) being requested as a change from **BRAND Zytiga** to allow the member access to their copay benefit? ☐ Yes ☐ No

3. What is the patient's diagnosis?

☐ Metastatic Castration-Resistant Prostate Cancer (CRPC)

a. Will Zytiga be used in combination with Lynparza? ☐ Yes ☐ No

b. Will Zytiga be used in combination with prednisolone? ☐ Yes ☐ No

c. Will Zytiga be used in combination with prednisone? ☐ Yes ☐ No

☐ Metastatic high-risk Castration-Sensitive Prostate Cancer (CSPC)

a. Will Zytiga be used in combination with prednisone? ☐ Yes ☐ No

☐ Non-metastatic very-high-risk prostate cancer

a. Will Zytiga be used in combination with prednisone or methylprednisolone? ☐ Yes ☐ No

☐ Other diagnosis (please specify): \_\_\_\_\_

4. Does the patient have a female partner of reproductive potential? ☐ Yes\* ☐ No

**\*If YES**, will the patient be advised to use effective contraception during treatment with Zytiga and for three weeks after the final dose? ☐ Yes ☐ No

5. Will Zytiga be used in combination with another \*androgen receptor inhibitor? ☐ Yes\* ☐ No

**\*If YES**, please specify medication: \_\_\_\_\_

**\*Androgen Receptor Inhibitors:** Erleada (apalutamide), Nilandron (nilutamide), Nubeqa (darolutamide), Xtandi (enzalutamide), Yonsa (abiraterone)



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<b>Electronically Online (ePA)</b> <b>Results in 2-3 minutes FASTEST AND EASIEST</b>	Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to <b>Caremark.com/ePA.</b>
<b>Phone</b> <b>(4-5 minutes for response)</b>	The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
<b>Fax</b> <b>(3-5 days for response)</b>	Fax the attached form to <b>(877)-378-4727</b> . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>

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	<b>CVS/caremark</b> 