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: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests for BRAND ZYTIGA are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage. SUBMITTING THE PATIENT'S MEDICAL RECORDS IS REQUIRED.

GENERIC Zytiga

(abiraterone acetate)

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

Please select strength: ❑**250 mg** ❑**500 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is this request for brand or generic? ***Please select answer below:***
   ❑**BRAND** Zytiga - please answer the questions on **PAGES 2-3**
   ❑**GENERIC** Zytiga (abiraterone acetate) - please answer the questions below:
2. How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days
3. Is abiraterone acetate (**GENERIC** Zytiga) being requested as a change from **BRAND** Zytiga? ❑Yes ❑No
4. What is the patient's diagnosis?
   ❑Metastatic castration-resistant prostate cancer (CRPC)
   a. Will this medication be used in combination with Lynparza? ❑Yes ❑No
   b. Will this medication be used in combination with prednisolone? ❑Yes ❑No
   c. Will this medication be used in combination with prednisone? ❑Yes ❑No
   ❑Metastatic high-risk castration-sensitive prostate cancer (CSPC)
   a. Will this medication be used in combination with prednisone? ❑Yes ❑No
   ❑Non-metastatic very-high-risk prostate cancer
   a. Will this medication be used in combination with prednisone or methylprednisolone? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____
5. 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 3 weeks after the final dose? ❑Yes ❑No
6. Will this medication be used in combination with another *androgen receptor inhibitor? ❑Yes* ❑No
   If YES, please specify medication: _____
   Androgen Receptor Inhibitors: Akeega (abiraterone/niraparib), Erleada (apalutamide), Nilandron (nilutamide), Nubeqa (darolutamide), Xtandi (enzalutamide), Yonsa (abiraterone)

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

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BRAND Zytiga

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

Please select strength: ❑**250 mg** ❑**500 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).

1. Is this request for brand or generic? ***Please select answer below:***
   - ❑**GENERIC** Zytiga (abiraterone acetate) - please answer the questions on **PAGE 1**
   - ❑**BRAND** Zytiga - please answer the questions below:
2. How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days
3. **Standard/Basic Option Patient:** Has the patient tried and failed generic Zytiga (abiraterone acetate)? ***Please select answer below:***
   - ❑ **YES – Please specify the medical record page number(s). PAGE(s)_____ of _____**
   - ❑ **NO – The patient has not tried and failed generic Zytiga (abiraterone acetate).** ***Please answer the questions below:***
     a. Would you like to switch to the preferred medication? The preferred medication is generic Zytiga (abiraterone acetate).
     - ❑ **YES –** Switch to generic Zytiga (abiraterone acetate).
     - ❑ **NO –** Do not switch.
     - ❑ **NO –** Do not switch however the patient has a medical exception. **Please specify the medical record page number(s). PAGE(s)_____ of _____**
     - ❑ **NO –** Do not switch however I would like to speak with a medical director to discuss the case. **Please specify the preferred date and time to contact, including the time zone, and the phone number:**_____
       _____
4. **Blue Focus Patient-** ***Please answer the questions below:***
   a. This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed. ***Please answer below:***
   - ❑**Please specify the formulary alternative medication(s) and medical record page number(s):**
     PAGE(s)_____ of _____ Formulary alternative medication(s):_____
     _____
   - ❑ **The patient has not tried and failed any formulary alternatives.**

   b. Would you like to switch to the preferred medication? The preferred medication is generic Zytiga (abiraterone acetate). ❑Yes ❑No

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

5. What is the patient's diagnosis? **DOCUMENTATION IS REQUIRED: Please ensure that all relevant medical records are submitted along with the correct page number(s).**

❑Metastatic castration-resistant prostate cancer (CRPC), **please specify the medical record page number(s) below: PAGE(s)_____ of _____**

a. Will this medication be used in combination with Lynparza? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

b. Will this medication be used in combination with prednisolone? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

c. Will this medication be used in combination with prednisone? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑Metastatic high-risk castration-sensitive prostate cancer (CSPC)

a. Will this medication be used in combination with prednisone? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑Non-metastatic very-high-risk prostate cancer

a. Will this medication be used in combination with prednisone or methylprednisolone? ❑Yes* ❑No
***If YES*, please specify the medical record page number(s). PAGE(s)_____ of _____**

❑Other diagnosis ***(please specify)***: _____

6. 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 3 weeks after the final dose? ❑Yes ❑No

7. Will this medication be used in combination with another *androgen receptor inhibitor? ❑Yes* ❑No

If YES, please specify medication: _____

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