Zytiga (abiraterone)

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: _________________ **Physician Office Fax:** ___________________
Request Initiated For: _______________________

1. What drug is being prescribed?
   ❑ Zytiga 250mg ❑ Zytiga 500mg ❑ abiraterone 250mg ❑ abiraterone 500mg

2. What is the patient's diagnosis?
   ❑ Metastatic prostate cancer
   ❑ Node positive prostate cancer
   ❑ Very-high-risk prostate cancer
   ❑ 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? ***If Erleada, Xtandi or Yonsa, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.coverymymeds.com/epa/caremark/ or call 1-866-452-5017. If bicalutamide, please submit new prescription to pharmacy.***
   ❑ Yes - abiraterone 250mg - *Fax new prescription to the pharmacy and skip to #10*
   ❑ Yes - abiraterone 500mg - *Fax new prescription to the pharmacy and skip to #10*
   ❑ Yes - bicalutamide
   ❑ Yes - Erleada
   ❑ Yes - Xtandi
   ❑ Yes - Yonsa
   ❑ 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. Has the patient experienced disease progression, had a documented intolerable adverse event or has a contraindication 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. Has the patient experienced disease progression, had a documented intolerable adverse event or has a contraindication 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. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
    ❑ Yes ❑ No *No further questions.*

13. Has the patient had a bilateral orchiectomy? *If Yes, no further questions.* ❑ Yes ❑ No

14. Will the requested medication be used in combination with a GnRH analog? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

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