Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

ZYTIGA & XTANDI
Prior Authorization Form

ZYTIGA IS THE PREFERRED MEDICATION FOR THE HEALTH PLAN

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
DOB:	Age:		NPI#:	Specialty:	
Health Plan ID#:			Phone:	Fax:	
Pharmacy Name:	Pharmacy Phone:		Office Contact:	Direct Phone # or Ext:	

Medication Information

☐ **ZYTIGA** (Abiraterone)	250mg Tablet	Directions:	Quantity Dispensed:	Day Supply:
☐ Xtandi (Enzalutamide)	40mg Capsules			
☐ New medication ☐ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

Diagnosis:_____ Date Diagnosed:_____

Does the member have a diagnosis of prostate cancer? ☐ Yes ☐ No

If no, please provide clinical literature/studies to support request for off-label use.

☐ Information included ☐ Information not available

Has the member received prior chemotherapy containing Docetaxel? ☐ Yes ☐ No

If no, please provide reason for not using Docetaxel first:_____

Does the member have metastatic disease? ☐ Yes ☐ No

Has the member previously tried androgen deprivation therapy? ☐ Yes ☐ No

If yes, please list drug(s) under Medication History.

Is the requested medication being used in combination with any other therapies? ☐ Yes ☐ No

If so, please provide name(s):_____

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Directions	Start Date	End Date	Reason for Discontinuing

Please provide any additional information which should be considered in the space below: