SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Jevtana® (Cabazitaxel) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ Physician billing (HCPCS code:_____)

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Diagnosis of metastatic, castration-resistant prostate cancer? Yes____ No_____
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Please indicate requested information:
   Yes____ No____ Member has previously received a docetaxel-containing regimen?
   Yes____ No____ Cabazitaxel request is for use in combination with prednisone?
4. Please provide dates/dose/duration of previous treatment: _____
   _____
   _____
5. Please provide member's body surface area (m^2): _____

Additional Information: _____
_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on cabazitaxel therapy?
   Yes____ No____
2. Has the member experienced adverse drug reactions related to cabazitaxel therapy?
   Yes____ No____

If yes, please specify adverse reactions: _____
_____

Additional Information: _____
_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*