SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Xtandi® (Enzalutamide) Prior Authorization Form

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

Drug Information

Pharmacy billing (NDC: _____**)**

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

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

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

Prescriber Information

Prescriber NPI: _____ ***Provider 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:_____

_____

Additional Information:_____

_____

_____

For Continued Authorization:

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

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

CONFIDENTIALITY NOTICE