SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Zytiga®/ Yonsa® (Abiraterone) 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: _____ ***Prescriber Name:*** _____

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

Criteria

For Initial Authorization:

1. Will abiraterone be used in combination with a corticosteroid? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ❑ Metastatic Castration-Resistant Prostate Cancer (CRPC)
     - A. Will abiraterone be used in combination with a gonadotropin-releasing hormone (GnRH) analog? Yes☐ No☐
     - B. Does member have a prior history of bilateral orchiectomy? Yes☐ No☐
   - ❑ Metastatic Castration-Sensitive Prostate Cancer (CSPC)
     - A. Does the member have high-risk disease? Yes☐ No☐
       - i. If answer to previous question is 'yes', please provide the following:
         - ❑ Total Gleason Score: _____
         - ❑ Number of lesions present on bone scan: _____
         - ❑ Is there evidence of measurable visceral metastases? Yes☐ No☐
   - ❑ If answer is none of the above, please indicate diagnosis: _____

Additional Information: _____

DRAFT

For Continued Authorization:

1. Date of last dose: _____
2. Does patient have any evidence of progressive disease while on abiraterone therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to abiraterone therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

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

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