OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare
Zytiga®/ Yonsa® (Abiraterone) Prior Authorization Form

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

Drug Information

Pharmacy Billing (NDC:_____***) Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Pharmacy Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy 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☐
   - ☐ **If answer is none of the above, please indicate diagnosis:**_____
3. If the request is for Zytiga® 500mg tablet (or generic abiraterone 500mg tablet), please provide a patient-specific, clinically significant reason why the member cannot use generic abiraterone 250mg tablets to achieve the requested dose: _____

_____

Additional Information:_____

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.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**