

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Xtandi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at  
**1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the  
Prior Authorization process.  
When conditions are met, we will authorize the coverage of Xtandi - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Xtandi (enzalutamide)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information

Patient Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient Group No.: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_  
Physician Phone: \_\_\_\_\_  
Physician Fax: \_\_\_\_\_  
Physician Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

Comments: \_\_\_\_\_

**Please circle the appropriate answer for each question.**

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?  Y  N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If no, skip to question 3.]

2. Is there clinical documentation showing the patient has had a beneficial response to treatment?  Y  N

NOTE: Submission of medical records is required.	
[If yes, skip to question 10.]	
[If no, no further questions.]	
3. Does the patient have a diagnosis of prostate cancer?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have metastatic castration-resistant disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 6.]	
5. Has the patient received prior treatment with docetaxel?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 7]	
[If no, no further questions.]	
6. Does the patient have metastatic high-risk castration-sensitive disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Will the patient be on concurrent therapy with a gonadotropin-releasing hormone analog?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
8. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Has the patient had a prior trial and inadequate response or intolerance with abiraterone or Zytiga?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Is the request for a male?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 12.]	
11. Is the request for female who is pregnant or may become pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
12. Does the patient have seizures or a low seizure threshold?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
13. Does either of the following apply to the patient: A) the request exceeds a quantity limit of 120 tablets per 30 days, B) the prescribed dose is greater than the Food and Drug Administration (FDA) approved dose of 160 milligrams daily?	<input type="checkbox"/> Y <input type="checkbox"/> N

[If yes, no further questions.]

14. Is the patient 18 years of age or older?

Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

**Prescriber (Or Authorized) Signature and Date**