PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Zytiga - 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 Zytiga - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Abiraterone Zytiga (abiraterone acetate)

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 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 9.]	
[If no, no further questions.]	
3. Does the patient have a diagnosis of prostate cancer?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have metastatic castration-resistant disease?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 6.]	
5. Does the patient have metastatic high-risk castration-sensitive prostate cancer?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Will the requested drug be used in combination with prednisone?	Y 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?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
8. Has the patient had bilateral orchiectomy?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the request for a male?	Y N
[If yes, skip to question 11.]	
10. Is the request for a female who is pregnant or may become pregnant?	Y N
[If yes, no further questions.]	
11. Does the patient have any of the following: A) an aspartate transaminase (AST) greater than 5 times the upper limit of normal (ULN), B) total bilirubin greater than 3 times the ULN, C) a left ventricular ejection fraction less than 50 percent, D) Class II to IV of New York Heart Association (NYHA) classification?	Y N
[If yes, no further questions.]	
12. 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 1000 milligrams daily?	Y N

[If yes, no further questions.]	
13. Is the request for brand name Zytiga?	Y N
[If no, skip to question 15.]	
14. Has the patient had a prior trial and inadequate response or intolerance with generic abiraterone?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
15. 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