Prior Authorization Request Form for
apalutamide (Erleada)

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name:	______________	Physician Name:	______________
Address:	______________	Address:	______________
	______________		______________
Sponsor ID #	______________	Phone #:	______________
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

Question	Yes	No
1. **Xtandi is the Department of Defense's preferred 2nd-Generation Antiandrogen agent.** **Has the patient tried Xtandi?**	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. **Does the patient have or have they had an inadequate response to Xtandi?**	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. **Does the patient have or have they had an adverse reaction to Xtandi that is not expected to occur with Erleada?**	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
4. **Does the patient have or have they had a contraindication to Xtandi?**	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. **Is the patient greater than or equal to 18 years of age?**	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**
6. **Is the requested medication being prescribed by or in consultation with an oncologist or urologist?**	☐ Yes Proceed to question **7**	☐ No **Stop** **Coverage not approved**
7. **Does the patient have a diagnosis of NON-METASTATIC castration-resistant prostate cancer (nmCRPC)?**	☐ Yes Proceed to question **8**	☐ No Proceed to question **10**
8. **Did the patient have a negative CT scan of abdomen and pelvis and/or negative bone scan?**	☐ Yes Proceed to question **9**	☐ No **Stop** **Coverage not approved**

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9. Does the patient have a prostate-specific antigen doubling time (PSADT) of less than or equal to 10 months?	☐ Yes Proceed to question **13**	☐ No **Stop** **Coverage not approved**
10. Does the patient have a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC)?	☐ Yes Proceed to question **13**	☐ No Proceed to question **11**
11. Please provide the diagnosis.	______________________________ Proceed to question **12**	
12. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Is this medication being prescribed in combination with a gonadotropin-releasing hormone analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	☐ Yes **Sign and date below**	☐ No Proceed to question **14**
14. Has the patient had bilateral orchiectomy?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

______________________________ Prescriber Signature

____________ Date

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: