

TRICARE Prior Authorization Request Form for
enzalutamide (**Xtandi**)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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.

Prior Authorization does not expire.

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:

1. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Stop Coverage not approved
2. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Stop Coverage not approved
3. For which indication is the requested medication being prescribed?	<input type="checkbox"/> METASTATIC castration-resistant prostate cancer (mCRPC) - Proceed to question 7 <input type="checkbox"/> NON-METASTATIC castration-resistant prostate cancer (nmCRPC) - Proceed to question 4 <input type="checkbox"/> METASTATIC castration-sensitive prostate cancer (mCSPC) - Proceed to question 7 <input type="checkbox"/> NON-METASTATIC castration-sensitive prostate cancer (nmCSPC) with biochemical recurrence at high risk for metastasis - Sign and date below <input type="checkbox"/> Other indication - Proceed to question 5	
4. Does the patient have a prostate-specific antigen doubling time (PSADT) of less than or equal to 10 months?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Stop Coverage not approved

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5. Please provide the diagnosis.	<hr style="width: 80%; margin: 0 auto;"/> <p>Proceed to question 6</p>	
6. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Stop Coverage not approved
7. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 8
8. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[26 June 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: