Prior Authorization Request Form for
Zytiga 250mg (abiraterone)

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:**

1. Yonsa is the Department of Defense's preferred CYP-17 Inhibitor agent. Has the patient tried Yonsa?	☐ Yes Proceed to question **3**	☐ No Proceed to question **2**
2. Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Yonsa that is not expected to occur with the requested agent?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. For which indication is the requested medication being prescribed?	☐ Metastatic castration-resistant prostate cancer (mCRPC) Proceed to question **8** ☐ Metastatic castration-sensitive prostate cancer (mCSPC) Proceed to question **8** ☐ Regional disease (TxN1M0) - Proceed to question **8** ☐ Other indication - Proceed to question **6**	

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6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving concomitant therapy with prednisone?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	☐ Yes Proceed to question **11**	☐ No Proceed to question **10**
10. Has the patient had bilateral orchiectomy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Zytiga 250 mg is the DoD's preferred strength. **Is the prescription for Zytiga 250mg OR will the prescription be changed to the 250 mg? Note:** *If the prescription is being changed to the 250 mg strength, please submit a new prescription.*	☐ Yes **Sign and date below**	☐ No Proceed to question **12**
12. Please state why the patient cannot take multiple 250 mg tablets to achieve the patient's daily dose.	**Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[31 July 2019]

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