TRICARE Prior Authorization Request Form for
abiraterone acetate (Zytiga) 250mg and 500mg

JOHNS HOPKINS
HEALTH PLANS
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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.

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?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ Metastatic castration-resistant prostate cancer (mCRPC) - Proceed to question **6** ☐ Metastatic castration-sensitive prostate cancer (mCSPC) - Proceed to question **6** ☐ Regional disease (TxN1M0) - Proceed to question **6** ☐ Other indication - Proceed to question **4**	
4. Please provide the diagnosis.	_____ Proceed to question **5**	

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5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient receiving concomitant therapy with prednisone?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient receiving concomitant therapy with a gonadotropin-releasing hormone (GnRH) analog (for example: Eligard, Lupron, Orgovyx, Trelstar, or Zoladex)?	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. 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

[26 June 2024]

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