Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Xtandi - 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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Xtandi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Xtandi (enzalutamide)

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 clinical 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 10.]	
[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 no, skip to question 6.]	
5. Has the patient received prior treatment with docetaxel?	Y N
NOTE: Submission of medical records is required.	
[If yes, skip to question 7]	
[If no, no further questions.]	
6. Does the patient have metastatic high-risk castration-sensitive disease?	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. Has the patient had a prior trial and inadequate response or intolerance with abiraterone or Zytiga?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Is the request for a male?	Y N
[If yes, skip to question 12.]	
11. Is the request for female who is pregnant or may become pregnant?	Y N
[If yes, no further questions.]	
12. Does the patient have seizures or a low seizure threshold?	Y N
[If yes, no further questions.]	
13. 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 160 milligrams daily?	Y N

[If yes, no further questions.]	
14. 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