



NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
[If no, no further questions.]	
3. Does the patient have a diagnosis of prostate cancer?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have metastatic castration-resistant disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 6.]	
5. Does the patient have metastatic high-risk castration-sensitive prostate cancer?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Will the requested drug be used in combination with prednisone?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 9.]	
8. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the request for a male?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 11.]	
10. Is the request for a female who is pregnant or may become pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
11. Does the patient have any of the following: A) an aspartate transaminase (AST) greater than 5 times the upper limit of normal (ULN), B) total bilirubin greater than 3 times the ULN, C) a left ventricular ejection fraction less than 50 percent, D) Class II to IV of New York Heart Association (NYHA) classification?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
12. 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 1000 milligrams daily?	<input type="checkbox"/> Y <input type="checkbox"/> N

[If yes, no further questions.]	
13. Is the request for brand name Zytiga?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 15.]	
14. Has the patient had a prior trial and inadequate response or intolerance with generic abiraterone?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
15. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> 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.

<b>Prescriber (Or Authorized) Signature and Date</b>