Androgen Biosynthesis Inhibitors: Abiraterone

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes:

   Is there clinical documentation of disease stability or improvement compared to baseline measures? ☐ Yes ☐ No

   What measures are being used to define disease stability or positive clinical response? _____

   When did treatment with the requested dose start? _____

2. Indicate patient's diagnosis:
   ☐ Metastatic castration resistant prostate cancer
   ☐ Metastatic high-risk castration sensitive or castration naïve prostate cancer
   ☐ Non-metastatic high-risk prostate cancer
   ☐ Other, specify: _____

   Indicate stage: _____

3. Was this prescribed by, or in consultation with, an oncologist or urologist?
   ☐ Yes ☐ No

4. Has the patient had a bilateral orchiectomy? ☐ Yes ☐ No
   If no, will the patient receive hormone suppression concurrently (e.g., GnRH therapy)? ☐ Yes ☐ No

5. Will Abiraterone be used in combination with a steroid consistent with FDA labeling (e.g. prednisone with Zytiga, methylprednisolone with Yonsa)?
   ☐ Yes ☐ No

6. Is the request for generic abiraterone 250mg tablets? ☐ Yes ☐ No
   If no, does patient have documented clinical rationale that 250mg tablets are not an effective regimen for patient? ☐ Yes ☐ No
   Provide clinical rationale: _____

For the diagnosis of metastatic high-risk castration sensitive or castration naïve prostate cancer:

7. Does the patient have any of the following risk factors? Check all that apply:
   ☐ Gleason score ≥ 7 (Grade Group > 2)
   ☐ Bone lesions
   ☐ Presence of measurable visceral metastases

8. If used in combination with docetaxel, does patient have high-volume metastatic burden? ☐ Yes ☐ No

For the diagnosis of Non-metastatic high-risk prostate cancer:

9. Indicate the following apply to the patient.
   ☐ Node positive

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☐ Node negative. Check all that apply:
- ☐ Gleason score ≥ 8
- ☐ Tumor stage T3 or T4
- ☐ Prostate-specific antigen (PSA) concentration ≥40 ng/mL
- ☐ Experienced prostate-specific antigen (PSA) doubling time of <6 months or PSA ≥20 ng/mL on androgen deprivation therapy (e.g. GnRH analogs)

10. Will Abiraterone be used in combination with the following? Check all that apply:
- ☐ External beam radiotherapy (EBRT), unless contraindicated
- ☐ Androgen deprivation therapy (ADT) (e.g. GnRH analogs)
- ☐ Prednisone or prednisolone

CHART NOTES, LABS AND TEST RESULTS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date