Zytiga (abiraterone)

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What drug is being prescribed? ❑ Zytiga ❑ abiraterone

2. What is the patient's diagnosis?
   ❑ Metastatic prostate cancer
   ❑ Node positive prostate cancer
   ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following questions if Zytiga is being prescribed. If abiraterone is being prescribed, skip to #10.

4. The preferred products for your patient's health plan are abiraterone, Xtandi, and Yonsa (for mCRPC only). Can the patient's treatment be switched to one of the preferred products? ***If Xtandi or Yonsa, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.coverymymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - abiraterone, *fax a new prescription to the pharmacy and skip to #10* ❑ Yes - Xtandi
   ❑ Yes - Yonsa (for mCRPC only) ❑ No - Continue request for Zytiga

5. Has the patient failed treatment with abiraterone (generic) due to a documented intolerable adverse event? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)?
   ACTION REQUIRED: If No, attach supporting chart note(s). *If Yes, complete this form in its entirety and State Step Therapy section.* ❑ Yes ❑ No

7. Is this a request for the treatment of metastatic castration sensitive prostate cancer (mCSPC)?
   ❑ Yes ❑ No *If No, skip to #9*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

 Zytiga [abiraterone] Onc Reg, State Step, ACSF SGM - 9/2020.

8. Has the patient experienced disease progression or a documented intolerable adverse event with the other preferred product Xtandi? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #10.***
❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

9. Has the patient experienced disease progression or a documented intolerable adverse event with both of the preferred products Xtandi and Yonsa? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

10. Will the requested medication be used in combination with either of the following classes of medication?
❑ Yes ❑ No
A. Second-generation oral anti-androgen (e.g., apalutamide [Erleada])
B. Oral androgen metabolism inhibitor (e.g., abiraterone acetate [Yonsa])

11. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #13*

12. Has the patient experienced disease progression or an unacceptable toxicity while receiving therapy with the requested medication? ❑ Yes ❑ No *No further questions.*

13. Has the patient had a bilateral orchiectomy? *If Yes, no further questions.* ❑ Yes ❑ No

14. Will the requested medication be used in combination with a GnRH analog? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?
❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (abiraterone, Xtandi, and Yonsa (for mCRPC only)) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (abiraterone, Xtandi, and Yonsa (for mCRPC only))?
❑ The alternate drug is contraindicated
❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
❑ The alternate drug is expected to be ineffective
❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
❑ The alternate drug is not in the patient's best interest
❑ None of the above
If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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