

ZYTIGA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services. Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office Contact:		Provider Specialty: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Transplant <input type="checkbox"/> ID <input type="checkbox"/> Other (Please List):		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:	Provider NPI #:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:	
Drug Requested:		<input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>				
<input type="checkbox"/> New Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes	
<input type="checkbox"/> Ongoing Medication			<input type="checkbox"/> No	
Diagnosis:		Patient Height:	Patient Weight:	

MEDICAL HISTORY

Does the member have a diagnosis Prostate cancer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If no, Please provide clinical literature/studies to support request for off-label use. <input type="checkbox"/> Information included <input type="checkbox"/> Information not available				
Has the member received prior chemotherapy containing docetaxel?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the member have metastatic disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the member previously tried hormonal therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, Please list drug(s):				
Is Zytiga being used in combination with any other therapies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please provide below. Also, please provide any other previous therapies tried below:				
Medication Trial/ Previous Therapies	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

Please provide any additional information which should be considered in the space below:
