UPMC Health Plan

ZYTIGA** and Xtandi

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:**		
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: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

☐ **New Medication** ☐ **Ongoing Medication**	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:

MEDICAL HISTORY

Does the member have a diagnosis of prostate cancer? ☐ **Yes** ☐ **No**

If no, please provide clinical literature/studies to support request for off-label use.

☐ **Information included**

☐ **Information not available**

Has the member received prior chemotherapy containing docetaxel? ☐ **Yes** ☐ **No**

If no, please provide reason for not using docetaxel first:

Does the member have metastatic disease? ☐ **Yes** ☐ **No**

Has the member previously tried androgen deprivation therapy? ☐ **Yes** ☐ **No**

If yes, please list drug(s):

Is the requested medication being used in combination with any other therapies? ☐ **Yes** ☐ **No**

If so, please provide name(s):

Please provide any other previous therapies tried below:

Medication Trial/ Previous Therapies	Dates of Therapy Start Date	Dates of Therapy End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

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

****ZYTIGA IS THE PREFERRED MEDICATION FOR UPMC HEALTH PLAN**