

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: <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"/> No
Diagnosis:			

MEDICAL HISTORY

Does the member have a diagnosis of 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	
If no, please provide reason for not using docetaxel first:				
Does the member have metastatic disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the member previously tried androgen deprivation therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please list drug(s):				
Is the requested medication being used in combination with any other therapies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If so, please provide name(s):				
Please provide any other previous therapies tried below:				
Medication Trial/ Previous Therapies	Dates of Therapy Start Date 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**