Xtandi® (Enzalutamide) Prior Authorization Form

Member Name:**______________________** ***Date of Birth:*****____________** ***Member ID#:*****________________**

Drug Information

Pharmacy billing (NDC:________________________) ***Start Date (or date of next dose):*****_______________**

Dose**:__________________________________** ***Regimen:*****_____________________________________**

Billing Provider Information

Pharmacy NPI:**__________________________** ***Pharmacy Name:*****_________________________________**

Pharmacy Phone:**__________________________** ***Pharmacy Fax:*****_________________________________**

Prescriber Information

Prescriber NPI:**_______________________** ***Prescriber Name:*****__________________________________**

Prescriber Phone:**______________** ***Prescriber Fax:*****_________________** ***Specialty:*****_______________**

Criteria

For Initial Authorization:

1. Is diagnosis castration-resistant prostate cancer (CRPC)? Yes____ No____
2. Is diagnosis metastatic castration-sensitive prostate cancer (CSPC)? Yes____ No____
3. If diagnosis is none of the above, please indicate diagnosis:_____________________________
   ____

Additional Information:____

____

For Continued Authorization:

1. Date of last dose:______________________
2. Does patient have any evidence of progressive disease while on enzalutamide therapy?
   Yes____ No____
3. Has the member experienced any adverse drug reactions related to enzalutamide therapy?
   Yes____ No____

If yes, please specify adverse reactions: ____

____

Additional Information:____

Prescriber Signature:___________________________ Date:_________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*