Agents for Prostate Cancer - Essential Formulary

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

Diagnosis Code: _____

Please select the requested medication and answer the following questions:

☐ Erleada	☐ Nubeqa	☐ Abirtega
☐ brand Zytiga 250mg	☐ generic abiraterone 250mg	☐ Xtandi
☐ brand Zytiga 500mg	☐ generic abiraterone 500mg	☐ Yonsa

1. Is the patient 18 years of age or older?..... ☐ Yes ☐ No
2. Is the patient managed by or in consultation with an oncologist or urologist?..... ☐ Yes ☐ No
3. Is the request for brand Zytiga, generic abiraterone or Abirtega?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a diagnosis of metastatic castration-resistant prostate cancer?..... ☐ Yes ☐ No
   b. Does the patient have a diagnosis of metastatic, high-risk castration-sensitive prostate cancer?..... ☐ Yes ☐ No
   c. Will the patient use the requested medication in combination with prednisone?..... ☐ Yes ☐ No
   d. Will the patient be using generic abiraterone 250mg tablets or Abirtega 250mg tablets?.....---..... ☐ Yes ☐ No
      i. **If NO,** please explain why using generic 250mg tablets or Abirtega 250mg tablets are not clinically appropriate for the patient:

      _____

      _____
4. Is the request for Yonsa?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a diagnosis of metastatic castration-resistant prostate cancer?..... ☐ Yes ☐ No
   b. Will the patient be using methylprednisolone in combination with Yonsa?..... ☐ Yes ☐ No
5. Is the request for Xtandi?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a diagnosis of castration-resistant prostate cancer?..... ☐ Yes ☐ No
   b. Does the patient have a diagnosis of metastatic castration-sensitive prostate cancer?..... ☐ Yes ☐ No
   c. Does the patient have a diagnosis of non-metastatic castration-sensitive prostate cancer, with biochemical recurrence at high risk for metastasis?..... ☐ Yes ☐ No

****continued on page 2; please complete and sign page 2 for prior authorization request****

Agents for Prostate Cancer (*continued*)
Essential Formulary

6. Is the request for Nubeqa?.....☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Does the patient have a diagnosis of non-metastatic castration-resistant prostate cancer?.....☐ Yes ☐ No
   b. Does the patient have a diagnosis of metastatic hormone-sensitive prostate cancer?.....☐ Yes ☐ No
      i. **IF YES,** will Nubeqa be used in combination with docetaxel?.....☐ Yes ☐ No

7. Is the request for Erleada?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a diagnosis of non-metastatic castration-resistant prostate cancer?.....☐ Yes ☐ No
   b. Does the patient have a diagnosis of metastatic castration-sensitive prostate cancer?.....☐ Yes ☐ No
   c. Will the patient be concurrently receiving a gonadotropin-releasing hormone (GnRH) analog?.....☐ Yes ☐ No
   d. Has the patient undergone a bilateral orchiectomy?.....☐ Yes ☐ No

8. Will the patient be using the requested medication for indications outside of FDA labeling?.....☐ Yes ☐ No
   IF YES, please indicate condition: _____
   Medical records and references / evidence must be provided in order for this request to be processed.

9. Is the patient currently taking the requested medication?.....☐ Yes ☐ No
   a. **IF YES,** is the patient taking the requested medication for a cancer diagnosis?.....☐ Yes ☐ No
      i. **IF YES,** will the patient be using the generic version of this medication?.....☐ Yes ☐ No
      ii. **IF NO,** please provide rationale for the use of the brand name medication **and SUBMIT SUPPORTING MEDICAL RECORD DOCUMENTATION**: _____
      _____

10. Is the requested medication a BRAND medication with an FDA approved AB rated generic equivalent?.....☐ Yes ☐ No
    a. **If YES,** has the patient tried the generic product of the requested medication?.....☐ Yes ☐ No
       If YES, please answer the following questions and SUBMIT MEDICAL RECORD DOCUMENTATION:
       i. Did the patient have a life-threatening side effect to the generic medication that required medical intervention that is not anticipated with the brand product?.....☐ Yes ☐ No
       ii. Did the prescriber complete and submit an FDA MedWatch Adverse Event Reporting form?.....☐ Yes ☐ No
       If YES, please provide a copy of the completed MedWatch form.

11. Please provide a clinical rationale for the requested medication and address alternatives that have not been tried, but may be clinically inappropriate; may include medical record documentation, laboratory results, and/or other supporting medical documentation (*omission of information indicates N/A or none*): _____
    _____

****PLEASE NOTE: If prescribing more than the program quantity limit (listed on page 3), please complete and sign* **page 3*******

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403

BlueCross BlueShield of North Carolina

COMPLETE PAGE 3 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR PROSTATE CANCER AGENTS

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX
PRESCRIBER ADDRESS	CITY / STATE / ZIP	
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH / GENDER M F

FOR COVERAGE OVER THE QUANTITY LIMITS (PROGRAM MAXIMUM PER DAY) LISTED BELOW, PLEASE ANSWER THE FOLLOWING:

Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2). Otherwise, this request will deny. ***Please note: Quantity limits apply to both brand and associated generic formulations***

Diagnosis Code:_____

Medication	Quantity per Day (unless specified)
Abirtega (abiraterone) 250 mg tablet	4 tablets
Zytiga (abiraterone) 250 mg tablet	4 tablets
Zytiga (abiraterone) 500 mg tablet	2 tablets
Yonsa (abiraterone) 125mg tablet	4 tablets
Xtandi (enzalutamide) 40 mg capsule	4 capsules
Xtandi (enzalutamide) 40 mg tablet	4 tablets
Xtandi (enzalutamide) 80 mg tablet	2 tablets
Nubeqa (darolutamide) 300mg tablet	4 tablets
Erleada (apalutamide) 60 mg tablet	4 tablets
Erleada (apalutamide) 240 mg tablet	1 tablet

Medication Name and Strength: _____

Requested Quantity per day: _____
****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be submitted.**

_____

_____

_____

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Prescriber's Signature (Required):_____ **Date**:_____

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