OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
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:***_____

Pharmacy 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. Please indicate the diagnosis and information:
   - ☐ **Castration-Resistant Prostate Cancer (CRPC)**
     - A. Will member receive concomitant treatment with a gonadotropin-releasing hormone analog or prior history of bilateral orchiectomy? Yes☐ No☐
     - B. Is diagnosis non-metastatic CRPC? Yes☐ No☐
       - i. If yes, Is PSA doubling time (PSADT) ≤10 months? Yes☐ No☐
     - C. Is diagnosis metastatic CRPC? Yes☐ No☐
       - i. If yes, is disease homologous recombination repair (HRR) gene-mutated? Yes☐ No☐
         1. If yes, will enzalutamide be used in combination with talazoparib? Yes☐ No☐
   - ☐ **Castration-Sensitive Prostate Cancer (CSPC)**
     - A. Is diagnosis metastatic CSPC? Yes☐ No☐
       - i. If yes, will member receive concomitant treatment with a gonadotropin-releasing hormone analog or prior history of bilateral orchiectomy? Yes☐ No☐
     - B. Is diagnosis non-metastatic CSPC with biochemical recurrence at high risk for metastasis (high-risk BCR)? Yes☐ No☐

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: _____

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.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*