OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Zytiga® / Yonsa® (abiraterone) 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. If requesting Yonsa®, will abiraterone be used in combination with methylprednisolone? Yes☐ No☐
2. If requesting Zytiga®, will abiraterone be used in combination with a corticosteroid? Yes☐ No☐
3. Will abiraterone be used concomitantly with a gonadotropin-releasing hormone (GnRH) analog? Yes☐ No☐
4. Does member have a prior history of bilateral orchiectomy? Yes☐ No☐
5. Will abiraterone be used in combination with niraparib? Yes☐ No☐
   a. If yes, is there presence of deleterious or suspected deleterious BRCA mutation based upon an FDA-approved test? Yes☐ No☐
6. Please indicate the diagnosis and information:
   - ☐ **Metastatic Castration-Resistant Prostate Cancer (CRPC)**
   - ☐ **Metastatic Castration-Sensitive Prostate Cancer (CSPC)**
     A. Does the member have high-risk disease? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:** _____
7. For Zytiga® 500mg tablet, please provide a patient-specific, clinically significant reason why the member cannot use generic abiraterone 250mg tablets: _____
8. For Yonsa®, please provide a patient-specific, clinically significant reason why the member cannot use generic abiraterone tablets: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does patient have any evidence of progressive disease while on abiraterone therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to abiraterone 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:

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

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