

State of Oklahoma Oklahoma Health Care Authority Jevtana® (Cabazitaxel) Prior Authorization Form

Member Name:	Date of Birth:	Member ID#:
	Drug Information	
	Physician billing (HCPCS code:)
Dose:		Start Date:
	Billing Provider Informa	
	c: Provider Name:	
Provider Phone:	Provider Fax:	
	Prescriber Information	on
	Prescriber Name:	
Prescriber Phone:	Prescriber Fax:	Specialty:
	Criteria	
	(Initial approval will be for the castration-resistant prostate cancel	
2. If answer is 'no' from pro	evious question, please indicate diaç	gnosis:
Yes No Ca	ember has previously received a doc abazitaxel request is for use in comb	
	's body surface area (m²):	
For Continued Authoriz 1. Does member have any Yes No	cation: v evidence of progressive disease where	hile on cabazitaxel therapy?
Yes No	enced adverse drug reactions relate	• •
If yes, please specify adver	rse reactions:	
Additional Information:		
Prescriber Signature:	tmont is modically necessary and all infi	Date:ormation is true and correct to the best of my
knowledge.		necessary. Failure to complete this form in full

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

will result in processing delays.

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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