

## State of Oklahoma Oklahoma Health Care Authority Zytiga®/ Yonsa® (Abiraterone) Prior Authorization Form

метрег	Date of Birth:_	Member ID#:
	Drug Inform	nation
Pharmacy I	billing (NDC:	)
Dose:R	Regimen:	Start Date:
	Billing Provider I	Information
Provider NPI:	Provider	Name:
Provider Phone: Provider Fax:		
	Prescriber Info	ormation
Prescriber NPI:	Prescri	iber Name:
Prescriber Phone:	Prescriber Fax:_	Specialty:
	Criteria	a
<ul> <li>A. Will abiraterone be analog? Yes</li> <li>B. Does member hav</li> <li>Metastatic Castration</li> <li>A. Does the member</li> </ul>	and information:  I-Resistant Prostate Cance used in combination with a No  Ye a prior history of bilateral I-Sensitive Prostate Cance have high-risk disease? Ye he above, please indicate	cer (CRPC) a gonadotropin-releasing hormone (GnRH)  I orchiectomy? Yes No cer (CSPC) es No e diagnosis:
Has the member experienced     If yes, please specify adverse read     Additional Information:	ce of progressive disease vany adverse drug reactions	while on abiraterone therapy? Yes No s related to abiraterone therapy? Yes No Date: and all information is true and correct to the best of m

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

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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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