SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Erleada® (Apalutamide) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Does member have a prior history of bilateral orchiectomy? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ❑ **Castration-Resistant Prostate Cancer (CRPC)**
     - A. Is diagnosis non-metastatic, castration-resistant prostate cancer? Yes☐ No☐
     - B. Has member had disease progression of non-metastatic prostate cancer while on androgen deprivation therapy? Yes☐ No☐
     - C. Prostate specific antigen doubling time:_____ months
     - D. Will apalutamide be used in combination with a gonadotropin-releasing hormone (GnRH) analog? Yes☐ No☐
   - ❑ **Castration-Sensitive Prostate Cancer (CSPC)**
     - A. Is diagnosis metastatic, castration-sensitive prostate cancer? Yes☐ No☐
     - B. Will apalutamide be used in combination with a luteinizing hormone-releasing hormone (LHRH) agonist/antagonist? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:** _____

For Continued Authorization:

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

*If yes, please specify adverse reactions:*_____

Additional Information:_____

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.*