Xtandi (enzalutamide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Metastatic castration-resistant prostate cancer ☐ Non-Metastatic castration-resistant prostate cancer ☐ Metastatic castration- sensitive prostate cancer ☐ Non-metastatic castration-sensitive prostate cancer ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will drug be used in combination with a clinical trial? ☐ Yes ☐ No

Will Xtandi(enzalutamide) be used in combination with a PARP Inhibitor such as; Zejula(niraparib), Lynparza(Olaparib), Talzenna(talazoparib), and/or Rubraca(rucaparib)? ☐ Yes ☐ No

For Non-Metastatic castration-resistant prostate cancer(M_0CRPC):
Does the prostate cancer have neuroendocrine differentiation, signet cell features, or small-cell features?
☐ Yes ☐ No

Has the patient been receiving androgen-deprivation therapy (such as flutamide, enzalutamide, bicalutamide, nilutamide) or a gonadotropin releasing hormone (such as Lupron Depot, Zolodex, Elidex, or Trelstar LA) ?
☐ Yes ☐ No
Please submit documentation of therapy(s) and dates of service.

Has the patient undergone bilateral orchiectomy? ☐ Yes ☐ No

Will patient continue on androgen-deprivation therapy while taking Xtandi? ☐ Yes ☐ No

Does the patient have castration-associated testosterone levels equaling no greater than 1.73nmol/L (0.50ng/L)?
☐ Yes ☐ No
Please submit lab documentation.

Does the patient have at least ONE prostate-specific antigen(PSA) value equaling 2ng/ml or greater? ☐ Yes ☐ No

Has the patient had at least THREE rising prostate-specific antigen (PSA) values in the past 10 months, obtained at an interval of at least one week apart during androgen deprivation? ☐ Yes ☐ No
Please submit lab documentation.

Is the patient's PSA doubling time of 10 months or less? ☐ Yes ☐ No
Please submit copies of all PSA levels obtained in the past 10months, required for review.

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Has the patient received prior treatment with any of the following: aminoglutethimide, ketoconazole, abiraterone acetate, or enzalutamide? □ **Yes** □ **No**

Has the patient received prior treatment with any investigational agent that inhibits androgen receptors or androgen synthesis? □ **Yes** □ **No**

For metastatic castration-sensitive prostate cancer(mCSPC)

Are the patient's metastases noted on computed tomography(CT) and/or bone scan? □ **Yes** □ **No**
Please submit the imaging report.

Was testosterone suppression initiated within the past 3 months? □ **Yes** □ **No**
Please submit chart documentation.

Did patient undergo no more than 24 months of adjuvant testosterone suppression AND discontinued it 12 or more months ago? □ **Yes** □ **No** ***Please submit chart documentation.***

For metastatic castration-resistant prostate cancer(mCRPC):

Will patient use Talzenna(talazoparib) in combination with Xtandi(enzalutamide)? □ **Yes** □ **No**

For Non-metastatic castration-sensitive prostate cancer(nmCSPC):
Does patient have a diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC)? □ **Yes** □ **No**
Please submit chart documentation.

Is patient at high-risk for biochemical recurrence with metastasis? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have a PSA doubling time ≤ 9 months? □ **Yes** □ **No** ***Please submit chart documentation.***

Did the patient have a prior radical prostatectomy? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have a PSA of ≥ 1ng/ml? □ **Yes** □ **No** ***Please submit chart documentation.***

Did the patient only have radiotherapy? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have a PSA at least 2ng/ml above the nadir? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have evidence of metastases? □ **Yes** □ **No** ***Please submit chart documentation.***

Does patient have a serum testosterone of ≥ 150ng/dL (5.2nmol/L)? □ **Yes** □ **No** ***Please submit chart documentation.***

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Has patient been previously treated with cytotoxic chemotherapy, aminoglutethimide, ketoconazole, abiraterone, or enzalutamide for prostate cancer? □ **Yes** □ **No** ***Please submit chart documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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