

State of Oklahoma  
Oklahoma Health Care Authority  
**Zytiga® (Abiraterone) Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Pharmacy billing (NDC: \_\_\_\_\_)  
Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_ Start Date: \_\_\_\_\_

**Billing Provider Information**

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_  
Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

1. Diagnosis of metastatic, castration resistant prostate cancer? Yes \_\_\_ No \_\_\_
  2. If answer is 'no' from previous question, please indicate diagnosis: \_\_\_\_\_
  3. Please indicate requested information:  
Yes \_\_\_ No \_\_\_ Abiraterone request is for use in combination with a corticosteroid?
- Additional Information: \_\_\_\_\_

**For Continued Authorization:**

1. Does patient have any evidence of progressive disease while on abiraterone therapy?  
Yes \_\_\_ No \_\_\_
  2. Has the member experienced any adverse drug reactions related to abiraterone 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:

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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