Prior Authorization Form

TYROSINE KINASE INHIBITORS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xtandi (enzalutamide).

Patient Information

Patient Name:

Patient Phone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Patient ID:

Patient Group No:

Patient DOB: ___ ___ / ___ ___ / ___ ___ ___ ___

Prescribing Physician

Physician Name:

Physician Phone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Physician Fax: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Physician Address:

City, State, Zip:

Drug Name (specify drug): Xtandi (enzalutamide)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1.	Zytiga is the Preferred Formulary Product for this patient's plan. Can the patient's treatment be switched to Zytiga?	**Y**	☐	**N**	☐
2.	Is the patient currently receiving treatment with Xtandi through health insurance? Note: If the patient is receiving Xtandi through samples or a manufacturer's patient assistance program, please answer 'No'.	**Y**	☐	**N**	☐
3.	Does the member have a diagnosis of metastatic, castration- resistant prostate cancer?	**Y**	☐	**N**	☐
4.	Has the patient experienced progression or documented contraindication/ intolerance to prior therapy with Zytiga?	**Y**	☐	**N**	☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

_____

Prescriber (Or Authorized) Signature and Date

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