Erleada (apalutamide)
Prior Authorization Request Form

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

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: PRIMETHERAPEUTICS.COM/NOPP

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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page

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

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:**
☐ Castration-resistant prostate cancer ☐ Metastatic castration- sensitive prostate cancer ☐ Other diagnosis: _____ICD-10_____	

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

Clinical Information:

<u>For Castration-resistant prostate cancer, answer the following:</u>

Does the patient have a prostate-specific antigen doubling time of 10 months or less while receiving continuous androgen-deprivation therapy, as documented in submitted lab reports or chart notes?* ☐ **Yes** ☐ **No**
Please provide documentation (i.e., lab reports or chart notes).
***Copies of lab reports showing all PSA levels obtained in the past 10 months need to be submitted for review as part of this prior authorization.**

Does the patient have distant metastatic disease identified on bone scan, as documented in submitted radiology report?* ☐ **Yes** ☐ **No**
Please provide radiology report.

Does the patient have distant metastatic disease identified on computed tomography (CT), as documented in submitted radiology report?* ☐ **Yes** ☐ **No**
Please provide radiology report.

Will the patient continue to be on an androgen-deprivation therapy, such as flutamide, Xtandi (enzalutamide), bicalutamide, nilutamide, or a gonadotropin releasing hormone such as Lupron Depot (leuprolide), Zoladex, (goserelin), Eligard (leuprolide), or Trelstar LA (triptorelin)? ☐ **Yes** ☐ **No**

Has the patient had an orchiectomy? ☐ **Yes** ☐ **No**

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

<u>For metastatic castration-sensitive prostate cancer, answer the following:</u>

Was patient receiving androgen deprivation therapy(ADT) at the time of disease progression? ☐ **Yes** ☐ **No**
Please provide chart notes.

Has patient had more than 6 cycles of docetaxel? ☐ **Yes** ☐ **No** ***Please provide chart notes.***

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

Has patient had more than 6 months of androgen deprivation therapy(ADT) for metastatic castration-sensitive prostate cancer? □ **Yes** □ **No**

Has the patient had more than 3 years of androgen deprivation therapy(ADT) for localized prostate cancer? □ **Yes** □ **No**

Has the patient had more than one surgery and/or more than one course of radiation therapy for symptoms of metastatic disease? □ **Yes** □ **No** ***Please provide chart notes.***

Has patient received radiation therapy in the past 12 months? □ **Yes** □ **No** ***Please provide chart notes.***

Has the patient undergone a prostatectomy in the past 12 months? □ **Yes** □ **No** ***Please provide chart notes.***

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/diagnosis 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:** _____

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FAX THIS FORM TO: 800-424-7640

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

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