

**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](http://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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page*

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
<b>2. LIST DIAGNOSES:</b>		<b>ICD-10:</b>
<input type="checkbox"/> Castration-resistant prostate cancer <input type="checkbox"/> Metastatic castration- sensitive prostate cancer <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b>  <b>For Castration-resistant prostate cancer, answer the following:</b> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation (i.e., lab reports or chart notes).</i> <i>*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.</i>  Does the patient have distant metastatic disease identified on bone scan, as documented in submitted radiology report?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide radiology report.</i>  Does the patient have distant metastatic disease identified on computed tomography (CT), as documented in submitted radiology report?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide radiology report.</i>  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)? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient had an orchiectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No  Will patient continue on androgen-deprivation therapy while taking Erleada? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>For metastatic castration-sensitive prostate cancer, answer the following:</b> Is patient's metastatic disease documented by greater than or equal to (>=) 1 bone lesions? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does patient have locally advanced disease? <input type="checkbox"/> Yes <input type="checkbox"/> No  Was patient receiving androgen deprivation therapy(ADT) at the time of disease progression? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide chart notes.</i>		

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

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?

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**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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**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