



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Prostate Cancer Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- | | | |
|---|---|---|
| <input type="checkbox"/> abiraterone 250 mg, 500 mg | <input type="checkbox"/> Nubeqa (darolutamide) | <input type="checkbox"/> Xtandi (enzalutamide) |
| <input type="checkbox"/> Erleada (apalutamide) | <input type="checkbox"/> Provenge (sipuleucel-T)^ | <input type="checkbox"/> Yonsa (abiraterone 125 mg) |
| <input type="checkbox"/> Jevtana (cabazitaxel) | <input type="checkbox"/> Xofigo (Radium Ra 223 dichloride)^ | |

J-Code (if applicable) _____

^This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

Dose of medication requested _____ **Frequency of medication requested** _____

Duration/Cycles of medication requested _____

Indication (Check all that apply.)

- Prostate cancer Other _____
- Metastatic Non-metastatic
- Castration-resistant Castration-sensitive

Please indicate prescriber specialty. Oncology Urology Other _____

Section I. Please complete for Jevtana requests.

- Has the member had an inadequate response to a docetaxel containing regimen? Yes No
- Please list previous regimen(s).
 Regimen _____ Dates of use _____
 Regimen _____ Dates of use _____

Section II. Please complete for Provenge requests.

- Does the member have an Eastern Cooperative Oncology Group (ECOG) performance score between 0-1?
 Yes No
 Please list ECOG performance score _____ over _____

2. Does the member have an estimated life expectancy > 6 months? Yes No
3. Does the member have hepatic metastases? Yes No
4. Does the member currently have symptoms? Yes No
If yes, are the symptoms minimal? Yes No (please explain) _____

Section III. Please complete for Xofigo requests.

Does the member have visceral metastatic disease? Yes No

Section IV. Please complete for abiraterone 250 mg and 500 mg, Erleada, Nubeqa, Xtandi, and Yonsa requests.

1. Will the requested medication be used in combination with a gonadotropin-releasing hormone (GnRH) analog?
 Yes. Drug name _____ Dose and frequency _____ No
2. Has the member had a bilateral orchiectomy? Yes No
3. For abiraterone 250 mg and 500 mg, does the member have metastatic high-risk castration-sensitive prostate cancer? Yes No
If yes, will the requested medication be used in combination with prednisone? Yes No
4. For Erleada and Xtandi for metastatic castration-sensitive prostate cancer, please provide clinical rationale for use instead of abiraterone. _____
5. For Yonsa, will the requested medication be used in combination with methylprednisolone? Yes No

Section V. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____
 NPI* _____ Individual MH Provider ID _____
 DEA No. _____ Office Contact Name _____
 Address _____ City _____ State _____ Zip _____
 E-mail address _____
 Telephone No.* _____ Fax No.* _____

* Required

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____