



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](http://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 or adverse reaction to a docetaxel containing regimen?  
 Yes  No
- Please list previous regimen(s).  
 Regimen \_\_\_\_\_ Dates of use \_\_\_\_\_  
 Regimen \_\_\_\_\_ Dates of use \_\_\_\_\_
- Will the requested medication be used in combination with prednisone?  Yes  No

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**Section II. Please complete for Provenge requests.**

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

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**Section III. Please complete for Xofigo requests.**

Does the member have visceral metastatic disease?  Yes  No

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**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 for metastatic castration-sensitive prostate cancer and Xtandi for metastatic castration-sensitive prostate cancer or metastatic castration-resistant prostate cancer, has the member tried abiraterone?  
 Yes. Please list the dates/duration of use, dose and frequency, and outcome below.  
Dates of use \_\_\_\_\_ Dose and frequency \_\_\_\_\_  
Did member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.  
\_\_\_\_\_  
 No. Explain why not. \_\_\_\_\_
5. For Erleada and Nubeqa for non-metastatic castration-resistant prostate cancer, has the member tried Xtandi?  
 Yes. Please list the dates/duration of use, dose and frequency, and outcome below.  
Dates of use \_\_\_\_\_ Dose and frequency \_\_\_\_\_  
Did member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.  
\_\_\_\_\_  
 No. Explain why not. \_\_\_\_\_
6. For Yonsa, will the requested medication be used in combination with methylprednisolone?  Yes  No

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**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.

\_\_\_\_\_  
\_\_\_\_\_

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**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*

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**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 \_\_\_\_\_