State of Oklahoma
Oklahoma Health Care Authority

SoonerCare Oklahoma Health Care Authority | SoonerSelect | aetna

Erleada® (Apalutamide) Prior Authorization Form

***Member Name:*________________________ ***Date of Birth:*_______________ ***Member ID#:*___________________

Drug Information

***Pharmacy billing (NDC:*________________________) ***Start Date (or date of next dose):*___________________

***Dose:*____ ***Regimen:*____

Billing Provider Information

***Provider NPI:*______________________________ ***Provider Name:*_________________________________

***Provider Phone:*_____________________________ ***Provider Fax:*_________________________________

Prescriber Information

***Prescriber NPI:*______________________ ***Prescriber Name:*____

***Prescriber Phone:*________________ ***Prescriber Fax:*__________________ ***Specialty:*__________________

Criteria

For Initial Authorization:

1. Does member have a prior history of bilateral orchiectomy? Yes☐ No☐
2. Please indicate the diagnosis and information:
   - ❑ **Castration-Resistant Prostate Cancer (CRPC)**
     - A. Is diagnosis non-metastatic, castration-resistant prostate cancer? Yes☐ No☐
     - B. Has member had disease progression of non-metastatic prostate cancer while on androgen deprivation therapy? Yes☐ No☐
     - C. Prostate specific antigen doubling time:__________ months
     - D. Will apalutamide be used in combination with a gonadotropin-releasing hormone (GnRH) analog? Yes☐ No☐
   - ❑ **Castration-Sensitive Prostate Cancer (CSPC)**
     - A. Is diagnosis metastatic, castration-sensitive prostate cancer? Yes☐ No☐
     - B. Will apalutamide be used in combination with a luteinizing hormone-releasing hormone (LHRH) agonist/antagonist? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:** ________________________________

For Continued Authorization:

1. Date of last dose:________________________
2. Does patient have any evidence of progressive disease while on apalutamide therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to apalutamide therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*____

Additional Information:____

Prescriber Signature:_____________________________________ **Date:**__________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*