



Oncology Agents: Antiandrogens- Oral – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
If yes, is there documentation demonstrating disease stability or a positive clinical response (e.g., decrease in tumor size or tumor spread, lack of disease progression)?
☐ Yes ☐ No
2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
☐ Oncologist ☐ Urologist
☐ Other. Specify: _____
3. Has patient had a bilateral orchiectomy? ☐ Yes ☐ No
4. Will patient use hormone suppression (e.g., GnRH therapy) with the requested medication?
☐ Yes ☐ No
5. Indicate patient's diagnosis and answer the associated questions as indicated:
☐ Castration-resistant prostate cancer (questions 6 - 8)
☐ Metastatic castration-sensitive prostate cancer (questions 9 - 11)
☐ Metastatic hormone-sensitive prostate cancer (questions 9 - 11)
☐ Non-metastatic castration-resistant prostate cancer (question 12)
☐ Non-metastatic castration-sensitive prostate cancer (question 12)
☐ Other. Specify: _____

For diagnosis of Castration-resistant prostate cancer:

6. Will the requested medication be used as monotherapy? ☐ Yes ☐ No
7. Has an HRR gene mutation been confirmed for patient? ☐ Yes ☐ No
If yes, will the request be used in combination with talazoparib (Talzenna)? ☐ Yes ☐ No
8. Has patient had treatment with abiraterone that was ineffective, not tolerated or contraindicated?
☐ Yes ☐ No

For diagnosis of metastatic castration-sensitive or hormone-sensitive prostate cancer:

9. Does patient have any of the following risk factors? Check all that apply:
- ☐ Gleason Score ≥ 7 (Grade Group ≥ 2)
 - ☐ Bone lesions
 - ☐ Presence of measurable visceral metastases
10. Has patient had treatment with abiraterone that was ineffective, not tolerated or contraindicated?
- ☐ Yes ☐ No
11. **If the request is for darolutamide (Nubeqa),** will it be used in combination with docetaxel?
- ☐ Yes ☐ No

For diagnosis of non-metastatic castration-resistant or castration-sensitive prostate cancer:

12. Does patient have any of the following risk factors? Check all that apply:
- ☐ Node positive
 - ☐ Gleason Score ≥ 8
 - ☐ Tumor stage T3 or T4
 - ☐ Prostate-specific antigen (PSA) concentration ≥ 40 ng/mL
 - ☐ Experienced prostate-specific antigen (PSA) doubling time of <6 months or PSA ≥ 20 ng/mL on androgen deprivation therapy (e.g. GnRH analogs)

Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request

Prescriber signature

Prescriber specialty

Date