

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) 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 (Initial approval will be for the duration of 6 months):

- 1. Diagnosis of metastatic, castration-resistant prostate cancer? Yes ___ No ___
 - 2. If answer is 'no' from previous question, please indicate diagnosis: _____
- Additional Information: _____

- 3. Please indicate requested information:
 - a. Does the member have symptomatic bone metastases? Yes ___ No ___
 - b. Does the member have known visceral metastatic disease? Yes ___ No ___
 - c. Will radium-223 (Xofigo[®]) be used in combination with chemotherapy? Yes ___ No ___
- 4. Please provide the following:
 - a. Member's absolute neutrophil count: _____ Date taken: _____
 - b. Member's platelet count: _____ Date taken: _____
 - c. Member's hemoglobin: _____ Date taken: _____
 - d. Member's body weight (kg): _____ Date taken: _____

For Continued Authorization:

- 1. Date of last dose: _____
- 2. Does member have any evidence of progressive disease while on radium-223 dichloride therapy?
Yes ___ No ___
- 3. Has the member experienced adverse drug reactions related to radium-223 dichloride therapy?
Yes ___ No ___

If yes, please specify adverse reactions: _____

- 4. Please provide the following:
 - a. Member's absolute neutrophil count: _____ Date taken: _____
 - b. Member's platelet count: _____ Date taken: _____

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.

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p>CONFIDENTIALITY NOTICE</p> <p><i>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.</i></p>
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