Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Print Clear

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

☐ abiraterone 250 mg, 500 mg
☐ Erleada (apalutamide)
☐ Jevtana (cabazitaxel)
☐ Provenge (sipuleucel-T)^
☐ Xofigo (Radium Ra 223 dichloride)^
☐ Xtandi (enzalutamide)
☐ Yonsa (abiraterone 125 mg)

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, frequency and duration of medication requested

Dose _____ Frequency _____

Duration/Cycles requested _____

Indication (Check all that apply.)

☐ Metastatic prostate cancer ☐ Non-metastatic castration-resistant prostate cancer ☐ Other _____

Please indicate prescriber specialty below.

☐ Oncology ☐ Urology ☐ Other _____

Section I. Please complete for Jevtana requests.

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

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) _____

Section III. Please complete for Xofigo requests.

1. Does the member have visceral metastatic disease?
   ☐ Yes ☐ No

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

1. 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
2. For Yonsa, will the requested medication be used in combination with methylprednisolone? ☐ Yes ☐ No
3. Will the requested medication be used in combination with a gonadotropin-releasing hormone (GnRH) analog?
   ☐ Yes. Drug name _____ Dose and frequency _____
   ☐ No
4. Has the member had a bilateral orchiectomy? ☐ 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 _____