Prescriber Criteria Form

Erleada 2025 PA Fax 2499-A v1 010125.docx
Erleada (apalutamide)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Erleada (apalutamide).

Drug Name:
Erleada (apalutamide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC)? [If yes, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC)? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested drug be used in combination with a gonadotropin-releasing hormone (GnRH) analog OR after bilateral orchiectomy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____