Prescriber Criteria Form Zytiga 2025 PA Fax 661-A v1 010125.docx Zytiga (abiraterone), Abiraterone 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 Zytiga.

Drug Name (select from list of drugs shown):

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 metastatic prostate cancer? [If yes, then skip to question 4.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of non-metastatic (M0) prostate cancer that meets any of the following: A) node-positive (N1), B) high-risk, C) prostate-specific antigen (PSA) persistence/recurrence following radical prostatectomy? [If yes, then skip to question 4.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of very-high-risk prostate cancer? [If no, then no further questions.]	Yes ◯	No ◯
4	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:**_____