

Prescriber Criteria Form

Zytiga 2024 PA Fax 661-A v1 010124.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:  
 Zytiga (abiraterone), Abiraterone

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

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 node-positive (N1), non-metastatic (M0) prostate cancer? [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:** \_\_\_\_\_