



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Zytiga

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient's ID: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
 Physician Office Address: \_\_\_\_\_

1. What drug is being prescribed?  Zytiga Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  Other \_\_\_\_\_
2. What is the diagnosis?  
 Metastatic prostate cancer  
 Other \_\_\_\_\_
3. What is the ICD9? \_\_\_\_\_
4. Is/was the cancer castration-resistant?  Yes  No
5. Prior to Zytiga therapy, did the patient receive prior chemotherapy containing docetaxel?  
 Yes  No
6. Is Zytiga used in combination with prednisone?  Yes  No
7. Is the patient currently receiving Zytiga therapy?  Yes  No *\*If no, no further questions*
8. Is the patient experiencing disease progression or unacceptable toxicity?  Yes  No  
*Definition of disease progression: 25 percent increase in prostate specific antigen [PSA] over the patient's baseline/nadir together with protocol-defined radiographic progression and symptomatic or clinical progression*
9. Has the patient initiated or is planning to initiate new treatment in addition to Zytiga?  Yes  No

**\*\*NOTE: We can NOT make a decision without documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_  
 Prescriber or Authorized Signature Date (mm/dd/yy)

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