SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Erleada® (Apalutamide) Prior Authorization Form

Member Name:____________________ Date of Birth:_____________ Member ID#:_________________

Drug Information

Pharmacy billing (NDC:______________________) Start Date (or date of next dose):_________________

Dose:_____________________________________ Regimen:____________________________________

Billing Provider Information

Provider NPI:___________________________ Provider Name:__________________________________

Provider Phone:____________________________ Provider Fax:________________________________

Prescriber Information

Prescriber NPI:____________________ Prescriber Name:_____________________________________

Prescriber Phone:______________ Prescriber Fax:________________ Specialty:________________

Criteria

For Initial Authorization:

1. Does member have a prior history of bilateral orchiectomy? Yes____ No_____
2. Please indicate the diagnosis and information:
   - ❑ **Castration-Resistant Prostate Cancer (CRPC)**
     - A. Is diagnosis non-metastatic, castration-resistant prostate cancer? Yes____ No_____
     - B. Has member had disease progression of non-metastatic prostate cancer while on androgen deprivation therapy? Yes____ No_____
     - C. Prostate specific antigen doubling time:_________ months
     - D. Will apalutamide be used in combination with a gonadotropin-releasing hormone (GnRH) analog? Yes____ No_____
   - ❑ **Castration-Sensitive Prostate Cancer (CSPC)**
     - A. Is diagnosis metastatic, castration-sensitive prostate cancer? Yes____ No____
     - B. Will apalutamide be used in combination with a luteinizing hormone-releasing hormone (LHRH) agonist/antagonist? Yes____ No____
   - ❑ **If answer is none of the above, please indicate diagnosis:** ______________________________

For Continued Authorization:

1. Date of last dose:______________________
2. Does patient have any evidence of progressive disease while on apalutamide therapy? Yes____ No____
3. Has the member experienced any adverse drug reactions related to apalutamide therapy? Yes____ No____

*If yes, please specify adverse reactions:*____

Additional Information:____

Prescriber Signature:__________________________________ Date:_______________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*