

State of Oklahoma Oklahoma Health Care Authority Provenge® (Sipuleucel-T) Prior Authorization Form

Member Name:	Date of Birth:	Member ID#:
	Drug Information	
Door	Physician billing (HCPCS code:) Start Date:
	Billing Provider Informat	
): Provider Name: Provider Fax:	
Provider Priorie.		
Drocoribor NDU	Prescriber Information	
	Prescriber Name:	Specialty:
Trescriber Frione.		Specialty
Con Initial Authorization	Criteria	luration of C months).
	(Initial approval will be for the d	·
1. Diagnosis of metastatic,	castration-resistant prostate cancer?	Yes No
2. If answer is 'no' from pre	vious question, please indicate diagr	nosis:
3. Please indicate requeste	ed information:	
Yes No Me	mber is asymptomatic or minimally s	ymptomatic?
Yes No Me	mber has hepatic metastases?	
Yes No Me	mber has a life expectancy greater th	nan six months?
4 Places provide dates/de	colduration of provious treatment:	
4. Flease provide dates/do:	se/duration of previous treatment:	
5. Please provide member's	s ECOG performance status:	· · · · · · · · · · · · · · · · · · ·
Additional Information:		
Prescriber Signature:	Da	ate:
I certify that the indicated treati knowledge.	nent is medically necessary and all inform	ate:
Please do not send in chart notes	. Specific information will be requested if ne	cessary. Failure to complete this form in full

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

will result in processing delays.

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

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