

State of Oklahoma Oklahoma Health Care Authority Xofigo® (Radium-223 Dichloride) Prior Authorization Form

| Member Name: | Date of Birtin | Member ID#: |
|--|---|---|
| | Drug Information | on |
| Physician billing (HCPCS code:_ |) Start Dat | te (or date of next dose): |
| Dose: | Regimen: | |
| | Billing Provider Info | rmation |
| Provider NPI: Provider Name: | | 9: |
| Provider Phone: | Provider Fax: | : |
| | Prescriber Inform | ation |
| Prescriber NPI: | Prescriber Name: | |
| Prescriber Phone: | Prescriber Fax: | Specialty: |
| | Criteria | |
| 3. Please indicate requested infor a. Does the member have sy b. Does the member have kn | mation: mptomatic bone metastases? own visceral metastatic diseas | se? YesNo |
| c. vviii radium-223 (Xotigo°) t 4. Please provide the following: | be used in combination with cr | nemotherapy? Yes No |
| a. Member's absolute neutro | phil count: | Date taken: |
| | | Date taken: |
| c. Member's hemoglobin: | | Date taken: |
| d. Member's body weight (kg |): | Date taken: |
| Yes No 3. Has the member experienced a Yes No | nce of progressive disease whit adverse drug reactions related | |
| If yes, please specify adverse reac4. Please provide the following: | ะนอกร: | |
| a Member's absolute neutro | ohil count: | Date taken: |
| b. Member's platelet count: _ | priii oount | Date taken: Date taken: |
| Additional Information: | | |
| Additional Information: | | Date: I information is true and correct to the bes |

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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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