



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Zytiga® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Prostate cancer

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have metastatic, castration-resistant (chemical or surgical) or castration-recurrent prostate cancer? Yes No

Does the patient have metastatic high-risk castration-sensitive prostate cancer? Yes No

Will the patient use Zytiga in combination with prednisone? Yes No

Will Zytiga be used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron [leuprolide], Zoladex [goserelin], Trelstar [triptorelin], Vantas [histrelin], Firmagon [degarelix])? Yes No

Has the patient received bilateral orchiectomy? Yes No

Is Zytiga prescribed by or in consultation with an oncologist or urologist? Yes No

Is this request for continuation of therapy? Yes No

Has the patient used Zytiga within the past 120 days? Yes No

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

Titration or loading-dose purposes

Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

Requested strength/dose is not commercially available

There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** _____

Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review ?

Please note: This request may be denied unless all required information is received.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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