

## Erleada - Washington Prior Authorization Request Form

Please complete this <u>entire</u> form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826.

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section B - Provider Information First Name:    Last Name:   M.D./D.O.	Address:  City: State: ZIP Code:  Phone: DOB: Allergies:  Primary Insurance Information (if any):  Is the requested medication: New or Continuation of Therapy? If continuation, list start date:  Is this patient currently hospitalized? Yes No If recently discharged, list discharge date:  Section B - Provider Information  First Name: Last Name: M.D./D.C.  Address: City: State: ZIP code:  Phone: Fax: NPI #: Specialty:  Office Contact Name / Fax attention to:  Section C - Medical Information  Medication: Strength:  Directions for use: Quantity:  Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE:  Is this member pregnant? Yes No Section D - Previous Medication Trials  Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation	section A – Member Infor	mattion						
State:   ZIP Code:	State:   ZIP Code:	First Name:		Last Name:			Memb	er ID:	
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Last Name:   Last Name:   M.D./D.O.	First Name:  Address:  City: State: ZIP code: Phone: Phone: Fax: NPI #: Specialty:  Office Contact Name / Fax attention to:  Section C - Medical Information Medication: Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant? Yes No If yes, what is this member's due date?  Section D - Previous Medication Trials Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation  Section E - Additional information and Explanation of why preferred medications would not meet the patient's need to the patie	Is this patient currently h	nospitalized?	Yes □ No	If recently	discharged, list discl	narge	date:	
Address:    City:   State:   ZIP code:	Address:  Phone:  Phon	Section B - Provider Infor	mation						
Phone: Fax: NPI #: Specialty:  Office Contact Name / Fax attention to:  Section C - Medical Information  Medication: Strength:  Directions for use: Quantity:  Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE:  Is this member pregnant? Yes No If yes, what is this member's due date?  Section D - Previous Medication Trials  Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation  Section E - Additional information and Explanation of why preferred medications would not meet the patient's need:	Phone: Fax: NPI #: Specialty:  Office Contact Name / Fax attention to:  Section C - Medical Information  Medication: Strength:  Directions for use: Quantity:  Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE:  Is this member pregnant? Yes No If yes, what is this member's due date?  Section D - Previous Medication Trials  Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation  Section E - Additional information and Explanation of why preferred medications would not meet the patient's need to the	First Name:			Last Name:			M.C	)./D.O.
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## Erleada - Washington **Prior Authorization Request Form**

Member First name:	Member Last name:	Member DOB:
	Clinical and Drug Specif	ic Information
ALL REQUESTS: - What is the patient's diagno	osis? (check which applies) Other	
Drugs and Biologics Composite States of the Drugs and Biologics of the Biologics of th	endium? □ Yes □ No	ational Comprehensive Cancer Network (NCCN)
Requests for PROSTATE CAN		
- Is the disease castration-re	sistant or recurrent? □ Yes □ No	
- Is the disease non-metasta	tic? 🗆 Yes 🗆 No	
- Did the patient have a bilate	eral orchiectomy?   Yes   No	
	nbination with a gonadotropin-releasi	ng hormone (GnRH) analog? □ Yes □ No
Requests for CONTINUATION		
- Does the patient show evid	ence of progressive disease while on	Erleada therapy? □ Yes □ No
	cumented positive clinical response to	
Provider Signature:		Date:

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