Zytiga (abiraterone acetate)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Metastatic castration-resistant prostate cancer	☐ Other (please state): _____ _____
Clinical Consideration	☐ Patient has had prior chemotherapy containing docetaxel ☐ Patient is taking Zytiga in combination with prednisone 5mg twice daily	
Physician Specialty	Diagnosis made by: ☐ Oncologist ☐ Other (please state):	
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Zytiga ® (abiraterone acetate) Strength _____ Sig _____ Qty _____ Refills	
	Please attach all relevant medical records and test results **We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (please sign and date)

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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