



Cabazitaxel-Jevtana Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

- Ambulatory Surgical (POS Code 24)
- Off Campus Outpatient Hospital (POS Code 19)
- Office (POS Code 11)
- Home (POS Code 12)
- On Campus Outpatient Hospital (POS Code 22)

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Cabazitaxel-Jevtana SGM 1932-A – 01/2024.

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Criteria Questions:

1. Does the patient have the diagnosis of metastatic castration-resistant prostate cancer (CRPC)?
 Yes, *Continue to 2*
 No, *Continue to 2*

2. Is the patient currently receiving treatment with the requested medication?
 Yes, *Continue to 3*
 No, *Continue to 4*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
 Yes, *No Further Questions*
 No, *No Further Questions*

4. Was the patient previously treated with any of the following?
 A docetaxel-containing regimen, *No further questions*
 Novel hormone therapy (e.g., enzalutamide [Xtandi], abiraterone [Zytiga]), *No further questions*
 No, *Continue to 5*

5. Was the patient not a candidate for or intolerant to docetaxel?
 Yes, *No Further Questions*
 No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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