SoonerSelect | aetna

State of Oklahoma
Oklahoma Health Care Authority

Jevtana® (Cabazitaxel) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ Physician billing (HCPCS code:_____)

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Diagnosis of metastatic, castration-resistant prostate cancer? Yes☐ No☐
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Please indicate requested information:
   Yes☐ No☐ Member has previously received a docetaxel-containing regimen?
   Yes☐ No☐ Cabazitaxel request is for use in combination with prednisone?
4. Please provide dates/dose/duration of previous treatment: _____
   _____
   _____
5. Please provide member's body surface area (m^2): _____

Additional Information: _____
_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on cabazitaxel therapy?
   Yes☐ No☐
2. Has the member experienced adverse drug reactions related to cabazitaxel therapy?
   Yes☐ No☐

If yes, please specify adverse reactions: _____
_____

Additional Information: _____
_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**