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State of Oklahoma
Oklahoma Health Care Authority
Provenge® (Sipuleucel-T) 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 is asymptomatic or minimally symptomatic?

   Yes____ No____ Member has hepatic metastases?

   Yes____ No____ Member has a life expectancy greater than six months?
4. Please provide dates/dose/duration of previous treatment: ___________________________________

   ____

   ____
5. Please provide member's ECOG performance status: _______________________________________

Additional Information: ____

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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**.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*