

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xtandi

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Detiant Name	Prescriber Name:	
Patient Name:	Supervising Physician:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable)	:
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Please provide the ICD diagnosis code for the above condition.		
Q2. For what diagnosis is the drug being prescribed (pick one)?		
☐ Metastatic castration-resistant prostate cancer ☐ Other		
Q3. If you selected "other" in question 2, please provide do higher recommendation per NCCN compendia or guideline		t with a category 1 or
Q4. Is prescribing physician a hematology or oncology spe	cialist?	
☐ Yes ☐ No		
Q5. Additional Comments:		



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Patient Name:	Prescriber Name: Supervising Physician:
Prescriber Signature	Date
□ Expedited/Urgent - By checking this box and sig	ing above, I certify that applying the standard review timeframe may

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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