

### PROVENGE (sipuleucel-t) PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Provenge** and **Quantity Limits/Daily Dose Limits** accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	PA# _____	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Provenge IV suspension	Quantity requested: <input type="checkbox"/> 3 x 250 mL bags <input type="checkbox"/> other: _____
Dose requested: <input type="checkbox"/> 1 infusion (1 x 250 ml) every 2 weeks x 3 total doses	<input type="checkbox"/> other: _____
Diagnosis:	Dx code (required):
1. Does the Recipient have a diagnosis of asymptomatic or minimally-symptomatic metastatic castrate-resistant (hormone-refractory) prostate cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of diagnosis or literature supporting the use of Provenge for the Recipient's diagnosis</i>
2. Is the Recipient currently taking any narcotic analgesics for the treatment of cancer-related pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit Recipient's complete current medication list.</i>
3. Will the Recipient be using concurrent chemotherapy or immunosuppressive agents while using Provenge?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit Recipient's complete current medication list and treatment regimen.</i>
4. What is the Recipient's ECOG performance status? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<i>Submit documentation.</i>
5. Does the Recipient have a life expectancy of more than 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
6. Does the Recipient have evidence of liver metastases?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
7. Did the Recipient have a bilateral orchiectomy?	<input type="checkbox"/> Yes – <i>submit documentation</i> <input type="checkbox"/> No – <i>submit recent testosterone level</i>

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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