

XOFIGO (radium ra-223 dichloride) PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Xofigo** 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"/> Xofigo IV single-dose vial	Quantity requested: <input type="checkbox"/> # _____ x 6 mL vials/single dose
Recipient’s weight: _____ lbs/kg	Dose requested: <input type="checkbox"/> 1 dose every 4 weeks x 6 total doses <input type="checkbox"/> other: _____
Diagnosis:	Dx code (required):
1. Does the Recipient have a diagnosis of castration-resistant prostate cancer with symptomatic bone metastases and no known visceral metastatic disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of diagnosis (for off-label use, include literature supporting the use of Xofigo for the Recipient’s diagnosis).</i>
2. Does the Recipient have malignant lymphadenopathy exceeding 3 centimeters?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
3. Does the Recipient have recent results of the following laboratory tests? <i>Check all that apply.</i> <input type="checkbox"/> absolute neutrophil count (ANC) <input type="checkbox"/> hemoglobin <input type="checkbox"/> platelet count	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit lab results for each test requested.</i>
4. 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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