OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Akeega™ (niraparib/abiraterone) Prior Authorization Form

Member Name:**________________** ***Date of Birth:*****______________** ***Member ID#:*****________________**

Drug Information

Pharmacy billing **(NDC:______________________)** ***Start Date (or date of next dose):*****_______________**

Dose:**______________________________________** ***Regimen:*****________________________________**

Pharmacy Information

Pharmacy NPI:**_________________________** ***Pharmacy Name:*****__________________________________**

Pharmacy Phone:**__________________________** ***Pharmacy Fax:*****______________________________**

Prescriber Information

Prescriber NPI:**_______________________** ***Prescriber Name:*****____________________________________**

Prescriber Phone:**_______________** ***Prescriber Fax:*****_________________** ***Specialty:*****________________**

Criteria

For Initial Authorization:

1. Please indicate diagnosis and information:

☐ **Castration-Resistant Prostate Cancer (CRPC)**

A. Is the diagnosis metastatic CRPC? Yes☐ No☐
B. Is there a presence of deleterious or suspected deleterious BRCA mutation based upon an FDA-approved test? Yes☐ No☐
C. Will niraparib/abiraterone acetate be used in conjunction with prednisone? Yes☐ No☐
D. Will niraparib/abiraterone acetate be used in conjunction with a gonadotropin-releasing hormone (GnRH) analog or is there a prior history of bilateral orchiectomy? Yes☐ No☐
E. Has member progressed on prior abiraterone therapy? Yes☐ No☐

☐ **If diagnosis is not listed above, please indicate diagnosis:** ________________________________

Additional information: ____

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For Continued Authorization:

1. Date of last dose:____________________________
2. Does member have any evidence of progressive disease while on niraparib/abiraterone acetate? Yes☐ No☐
3. Has member experienced adverse drug reactions related to niraparib/abiraterone acetate 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.

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. 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.*