

Prescriber Criteria Form

Xtandi 2026 PA Fax 816-A v1 010126.docx

Xtandi (enzalutamide)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xtandi (enzalutamide).

Drug Name:
Xtandi (enzalutamide)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC) with biochemical recurrence at high risk for metastasis (high-risk BCR)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of castration-resistant prostate cancer (CRPC)? [If yes, then skip to question 4.]	Yes	No
3	Does the patient have a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC)? [If no, then no further questions.]	Yes	No
4	Will the requested drug be used in combination with a gonadotropin-releasing hormone (GnRH) analog OR after bilateral orchiectomy?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date: _____

