



# Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

**Complete form in its entirety and fax to  
1-877-528-5816, Attn. PA pharmacist.**

Contact Blue Advantage Medical Management at  
1-866-508-7145 if you have questions.

## **PART B DRUG PRIOR AUTHORIZATION REQUEST FORM**

**PROVENGE® (sipuleucel-T)**  
**If criteria is met, Provenge will be approved for a total  
of three doses.**

### **Request Type:**

- Standard Review (14 days)
- Expedited Review (72 hours) – By checking this box I certify that applying the 14-day standard review timeframe might seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

**NOTE: Please complete all fields in the form. Missing information and lack of prompt response to requests for additional information may delay response time. Please attach relevant supporting documentation such as labs, results of diagnostic tests and office visit notes to this request.**

### **PATIENT INFORMATION**

Patient Name		DOB		
Street Address, City, State, ZIP				
Plan Member ID#	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Weight	Height	BMI

Drug Allergies

### **PRESCRIBER INFORMATION**

Prescriber Name	Office Contact Person and Direct Extension
Street Address, City, State, ZIP	
Office Phone	Office Fax

### **DRUG DISPENSING AND ADMINISTRATION INFORMATION**

Facility Where Drug is to be Administered	Next Treatment Date
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### **DIAGNOSIS AND CLINICAL INFORMATION**

Does the patient have metastatic prostate cancer?

Yes     No

If yes, please indicate site of metastases:

bone     soft tissue     visceral (e.g. lung, liver, brain) *Please specify site:*

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Has the patient been treated with hormone therapy (e.g. Lupron, Eligard, Zoladex, Trelstar)?

Yes     No

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Is the patient currently being treated with opioids for cancer-related pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient received chemotherapy for prostate cancer in the past three months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient received systemic steroids in the past month? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is life expectancy greater than six months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the patient's ECOG performance status?	
<b>Feel free to provide additional information you feel is relevant to the request below:</b>	
Prescriber Signature	Date

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