pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PROVENGE (sipuleucel-t) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Provenge** (**sipuleucel-t**) and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	☐Provenge IV suspension	**Quantity requested:**	☐3 x 250 mL bags ☐other: _____
Dose requested:	☐1 infusion (1 x 250 ml) every 2 weeks x 3 total doses	☐other: _____	
Diagnosis:		Dx code (*required*):	

Does the beneficiary have a diagnosis of asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone-refractory) prostate cancer?	☐Yes ☐No	*Submit documentation of diagnosis or literature supporting the use of Provenge for the beneficiary's diagnosis.*
Is the beneficiary currently taking any opioid analgesics for the treatment of cancer-related pain?	☐Yes ☐No	*Submit beneficiary's complete current medication list.*
Will the beneficiary be using concurrent chemotherapy or immunosuppressive agents while using Provenge?	☐Yes ☐No	*Submit beneficiary's complete current medication list and treatment regimen.*
What is the beneficiary's ECOG performance status? ☐0 ☐1 ☐2 ☐3 ☐4		*Submit documentation.*
Does the beneficiary have a life expectancy of more than 6 months?	☐Yes ☐No	*Submit documentation.*
Does the beneficiary have evidence of liver metastases?	☐Yes ☐No	*Submit documentation.*
Did the beneficiary have a bilateral orchiectomy?	☐Yes – *Submit documentation*. ☐No – *Submit recent testosterone level.*	

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

Prescriber Signature:	Date: