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

XOFIGO (radium ra-223 dichloride) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Xofigo (radium ra-223 dichloride)** 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: ☐Xofigo IV single-dose vial	**Quantity requested:** ☐#___________ x 6 mL vials/single dose
Beneficiary's weight: ______________ lbs/kg	**Dose requested:** ☐1 dose every 4 weeks x 6 total doses ☐other: ___________
Diagnosis:	Dx code (*required*):
Does the beneficiary have a diagnosis of castration-resistant prostate cancer with symptomatic bone metastases and no known visceral metastatic disease?	☐Yes ☐No *Submit documentation of diagnosis (for off-label use, include literature supporting the use of Xofigo for the beneficiary's diagnosis).*
Does the beneficiary have malignant lymphadenopathy exceeding 3 centimeters?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have recent results of the following laboratory tests? *Check all that apply.* ☐absolute neutrophil count (ANC) ☐hemoglobin ☐platelet count	☐Yes ☐No *Submit lab results for each test requested.*
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:

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