HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter.

TRICARE authorizes coverage for PROVENGE® (sipuleucel-T) in limited circumstances. PROVENGE is given through three separate IV infusions two weeks apart. Please provide the following information:

1 Is there evidence of metastatic prostate cancer to lymph nodes, bone and/or soft tissue? ☐ Yes ☐ No

2. Is there evidence of metastatic prostate cancer to liver, lung or brain? ☐ Yes ☐ No

3 Has the patient failed hormonal therapy? ☐ Yes ☐ No

4. Has the patient had bilateral orchiectomy (removal of the testes)? ☐ Yes ☐ No

   Date of bilateral orchiectomy: _____

5. Is the patient taking medication to achieve chemical castration? (Examples of medications that meet this criteria include, Leuprolide (Lupron, Viodur, Eligard), Goserelin (Zoladex), Triptorelin (Trelstar), Histrelin (Supprelin LA,Vantas), and Degarelix (Firmagon).) ☐ Yes ☐ No

   Name of Drug: _____

   Date of Onset of Treatment: _____

6. Is the patient's testosterone at castrate level (serum testosterone < 50 mg/dl)? ☐ Yes ☐ No

   Serum testosterone level: _____mg/dl.

   Date of serum testosterone level: _____

7. Is there evidence of persistently elevated or rising PSA? ☐ Yes ☐ No

8. Is the PSA greater than or equal to five? ☐ Yes ☐ No

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9. Is there evidence of increasing PSA on three successive reports? ☐ Yes ☐ No

PSA Result (1): _____ Date: _____

PSA Result (2): _____ Date: _____

PSA Result (3): _____ Date: _____

10. Is there evidence of progression of the metastatic disease? ☐ Yes ☐ No

Please explain: _____

11. Asymptomatic or minimally symptomatic (ECOG score 0 or 1)? (See table below)

ECOG score: _____

Eastern Cooperative Oncology Group (ECOG) Performance Status	
STATUS	**GRADE**
Fully active, able to carry on all pre-disease performances without restriction	0
Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, for example, light house work or office work	1
Ambulatory and capable of all self-care but unable to carry out any work activities, up and about more than 50 percent of waking hours	2
Capable of only limited self-care, confined to bed or chair more than 50 percent of waking hours	3
Completely disabled, cannot carry on any self-care or totally confined to bed or chair	4
Dead	5

12. Does the patient have a life-expectancy of at least six months? ☐ Yes ☐ No

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title: _____

TIN: _____

Signature: _____ Date: _____