US Family Health Plan
Prior Authorization Request Form for
darolutamide (**Nubeqa**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire in 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 Please complete the clinical assessment:

1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE/USFHP approved PA for Nubeqa*	☐ Yes (subject to verification) Proceed to question 1**3**	☐ No Proceed to question **2**
2. Xtandi is the Department of Defense's preferred 2nd-Generation Antiandrogen agent. **Has the patient tried Xtandi?**	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Does the patient have or have they had a contraindication/inadequate response/adverse reaction to Xtandi that is not expected to occur with the requested agent?	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to question **6**	☐ No **Stop** **Coverage not approved**
6. Does the patient have a diagnosis of NON-METASTATIC castration-resistant prostate cancer?	☐ Yes Proceed to question **7**	☐ No Proceed to question **9**
7. Did the patient have a negative CT scan of abdomen and pelvis and/or negative bone scan?	☐ Yes Proceed to question **8**	☐ No **Stop** **Coverage not approved**

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8. Does the patient have a prostate-specific antigen doubling time (PSADT) of less that than or equal to 10 months?	☐ Yes Proceed to question **11**	☐ No **Stop** **Coverage not approved**
9. Please provide the diagnosis.	_____ Proceed to question **10**	
10. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Is this medication being prescribed in combination with a gonadotropin-releasing hormone analog (for example: Eligard, Lupron, Trelstar, or Zoladex)?	☐ Yes **Sign and date below**	☐ No Proceed to question **12**
12. Has the patient had bilateral orchiectomy?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**
13. Does the patient continue to be free of metastases?	☐ Yes Proceed to question **14**	☐ No **Stop** **Coverage not approved**
14. Has the patient progressed onto subsequent therapy (such as abiraterone)?	☐ Yes **Stop** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[19 February 2020]