US Family Health Plan
Prior Authorization Request Form for
Nilutamide (Nilandron)

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 855-273-5735

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**

Clinical documentation may be required for approval.

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 tried bicalutamide (Casodex) or flutamide and experienced therapeutic failure?	☐ Yes **Sign and date below**	☐ No Proceed to question **2**
2. Has the patient tried bicalutamide (Casodex) or flutamide and experienced significant adverse effects?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Does the patient have a contraindication to bicalutamide (Casodex) and flutamide?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Does the patient have a diagnosis of metastatic prostate cancer (stage D2) disease?	☐ Yes Proceed to question **5**	☐ No Proceed to question **6**
5. Has the patient undergone orchiectomy?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
6. Please provide the diagnosis.	_____ Proceed to question **7**	
7. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[14 August 2019]