

TRICARE Prior Authorization Request Form for
darolutamide (Nubeqa)



JOHNS HOPKINS
HEALTH PLANS

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**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization will expire in 1 year.

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

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

Step 2 Please complete the clinical assessment:

1. Xtandi is the Department of Defense's preferred 2nd-Generation Antiandrogen agent. Has the patient tried Xtandi?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 2
2. 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?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Stop Coverage not approved
3. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Stop Coverage not approved
4. Is the requested medication being prescribed by or in consultation with an oncologist or urologist?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Stop Coverage not approved
5. Does the patient have a diagnosis of NON-METASTATIC castration-resistant prostate cancer (nmCRPC)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 8
6. Did the patient have a negative CT scan of abdomen and pelvis and/or negative bone scan?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 9

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7. Does the patient have a prostate-specific antigen doubling time (PSADT) of less than or equal to 10 months?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 9
8. Does the patient have a diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 9
9. Please provide the diagnosis.	<hr style="width: 80%; margin: 0 auto;"/> 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?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 12
12. Has the patient had bilateral orchiectomy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[5 June 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: