Prior Authorization Request Form for
darolutamide (Nubeqa)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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.

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 approved PA for Nubeqa*	☐ Yes (subject to verification) Proceed to question **13**	☐ 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**

Prior Authorization Request Form for
darolutamide (Nubeqa)

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]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: