

Nubeqa (darolutamide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](https://www.primetherapeutics.com/nopp)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Castration-resistant prostate cancer <input type="checkbox"/> Metastatic hormone-sensitive prostate cancer <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Clinical Information:</p> <p><u>Initial Request:</u></p> <p>For Castration-resistant prostate cancer, please answer the following:</p> <p>Is the patient's disease confirmed to be adenocarcinoma of the prostate without neuroendocrine differentiation or small cell features? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i></p> <p>Does the patient have castrate level of serum testosterone equaling less than 1.7nmol/L (50 ng/dL) while on GnRH agonist (or antagonist) therapy or after bilateral orchiectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i></p> <p>Does the patient have a prostate-specific antigen (PSA) doubling time less than or equal to 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i></p> <p>Does the patient have a PSA level greater than or equal to 2 ng/ mL? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i></p> <p>Is the patient Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 (is ambulatory and can carry out light work activities)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Does the patient have metastases? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>If the patient has metastases, are the only metastases 2cm or smaller and located in the pelvic lymph node region? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p><u>Initial Request:</u></p> <p>For Metastatic hormone-sensitive prostate cancer, please answer the following:</p> <p>Will Nubeqa(darolutamide) be used in combination with docetaxel? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does patient have an ECOG status of 0 or 1? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Has patient had prior treatment more than 12 weeks with an LHRH agonists such as Leuprolide (Lupron, Eligard), Goserelin (Zoladex), Triptorelin (Trelstar), or Leuprolide mesylate (Camcevi), before use with Nubeqa(darolutamide)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p>		

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Has patient had prior treatment more than 12 weeks with an LHRH antagonist such as Firmagon(degarelix) before use with Nubeqa(darolutamide)? Yes No *Please submit documentation.*

Has patient had prior treatment with a second- generation androgen receptor antagonist such as Zytiga(alibraterone), Xtandi(enzalutamide), or Erleada(apalutamide)? Yes No Please submit documentation.

Has patient had prior treatment with a CYP-17 inhibitor such as Yonsa(abiraterone) or ketoconazole as an antineoplastic treatment for prostate cancer? Yes No Please submit documentation.

Has patient received chemotherapy or immunotherapy for prostate cancer? Yes No Please submit documentation.

Renewal Request:

Is patient continuing to demonstrate a positive clinical response? Yes No Please submit documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 877-228-7909