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: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

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:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Castration-resistant prostate cancer ☐ Metastatic hormone-sensitive prostate cancer ☐ Other diagnosis:_____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Initial Request:

For Castration-resistant prostate cancer, please answer the following:

Is the patient's disease confirmed to be adenocarcinoma of the prostate without neuroendocrine differentiation or small cell features? ☐ **Yes** ☐ **No** ***Please submit documentation***

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? ☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a prostate-specific antigen (PSA) doubling time less than or equal to 12 months?
☐ **Yes** ☐ **No** ***Please submit documentation***

Does the patient have a PSA level greater than or equal to 2 ng/ mL? ☐ **Yes** ☐ **No** ***Please submit documentation***

Is the patient Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 (is ambulatory and can carry out light work activities)? ☐ **Yes** ☐ **No** ***Please submit documentation.***

Does the patient have metastases? ☐ **Yes** ☐ **No** ***Please submit documentation.***

If the patient has metastases, are the only metastases 2cm or smaller and located in the pelvic lymph node region?
☐ **Yes** ☐ **No** ***Please submit documentation.***

Initial Request:

For Metastatic hormone-sensitve prostate cancer, please answer the following:
Will Nubeqa(darolutamide) be used in combination with docetaxel? ☐ **Yes** ☐ **No**

Does patient have an ECOG status of 0 or 1? ☐ **Yes** ☐ **No** ***Please submit documentation.***

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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)? □ Yes □ No ***Please submit documentation.***

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:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909