Prescriber Criteria Form Nubeqa 2024 PA Fax 3149-A v2 010124.docx Nubeqa (darolutamide) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nubeqa (darolutamide).

Drug Name: Nubeqa (darolutamide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC)? [If yes, then skip to question 3.]	Yes	No
2	Does the patient meet both of the following: A) the patient has a diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC), B) the requested drug will be used in combination with docetaxel? [If no, then no further questions.]	Yes	No
3	Will the requested drug be used in combination with a gonadotropin-releasing hormone (GnRH) analog OR after bilateral orchiectomy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____