

NILANDRON PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Federal Employee Program.

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: Male	Female	Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R	1 1 1		Physician Signature:		
PHYSICIAN COMPLETES					

Nilandron (nilutamide)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? \Box Brand \Box Generic

- 1. What is the patient's diagnosis?
 - □ Metastatic Prostate Cancer
 - □ Other diagnosis (*please specify*): _
- Will Nilandron be used in combination with another *androgen receptor inhibitor? □Yes □No
 *Androgen receptor inhibitors include: Erleada (apalutamide), Nubeqa (darolutamide), Xtandi (enzalutamide), Yonsa (abiraterone), and Zytiga (abiraterone)
- 3. Has the patient been on Nilandron continuously for the last 6 months, excluding samples? Please select answer below:

NO – this is **INITIATION** of therapy, please answer the following questions:

- a. Has the patient had a contraindication, intolerance, or inadequate treatment response to generic nilutamide? \Box Yes \Box No
- b. Has the patient had a contraindication, intolerance, or inadequate treatment response to Bicalutamide? Yes
- c. Has the patient had a contraindication, intolerance, or inadequate treatment response to Flutamide? Yes No
- d. Has the patient had a baseline liver enzymes test that show no severe hepatic impairment? Yes No
- e. Has the patient had a chest x-ray that rules out severe respiratory insufficiency findings? □Yes □No
- f. Will the patient be undergoing surgical castration while on Nilandron? Yes No
- **YES** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
 - a. Does the patient have severe respiratory insufficiency? **D**Yes **D**No
 - b. Does the prescriber agree to monitor ALT and AST levels at regular intervals? \Box Yes \Box No



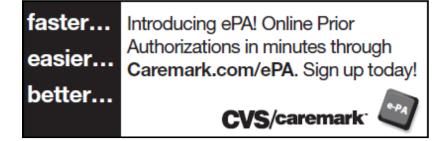
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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug prior authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM- 9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. <u>Please only fax the completed form once as</u> <u>duplicate submissions may delay processing</u> <u>times.</u>



The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** Lertify all information provided on this form to be true and correct to the best of my knowledge and belief. Lunderstand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and lagree to provide any such information to the insurer. Nilandron – EPE CSU_MD Fax Form Revised 9/20/2019