BlueCross BlueShield Federal Employee Program

NUBEQA
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

Additional information is required to process your claim for prescription drugs. Please complete the patient 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**			Physician Signature:		
PHYSICIAN COMPLETES					

Nubeqa (darolutamide)

****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? ❑Brand ❑Generic

Will the patient need more than 360 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets every 90 days

1. Is the patient assigned male at birth? ❑Yes ❑No

2. Does the patient have a diagnosis of non-metastatic castration-resistant prostate cancer (nmCRPC) OR metastatic castration-sensitive prostate cancer (mCSPC)? ***Please select answer below:***

   ❑Yes, non-metastatic castration-resistant prostate cancer (nmCRPC)

   ❑Yes, metastatic castration-sensitive prostate cancer (mCSPC)

   ❑No

3. Does the patient have a female partner of reproductive potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Nubeqa and for one week after the last dose? ❑Yes ❑No

4. Is the patient receiving a gonadotropin-releasing hormone (GnRH) agonist or antagonist? ❑Yes ❑No

5. Has the patient had a bilateral orchiectomy? ❑Yes ❑No

6. Will this medication be used in combination with another Prior Authorization (PA) androgen receptor inhibitor? ❑Yes* ❑No

   If YES, please specify the medication: _____

   ***Androgen Receptor Inhibitors: Akeega (abiraterone/niraparib), Erleada (apalutamide), Nilandron (nilutamide), Xtandi (enzalutamide), Yonsa (abiraterone), Zytiga (abiraterone**)

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:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand 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 I agree to provide any such information to the insurer. Nubeqa – FEP MD Fax Form Revised 7/25/2025