

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION
Nilandron (FA-PA)

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Nilandron (FA-PA).

Drug Name (select from list of drugs shown)

Nilandron (nilutamide)

Quantity	Frequency	Strength
Route of Administration		Expected Length of Therapy

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Y N
Can your patient's treatment be switched to a formulary drug? [If yes, provide your patient with a new prescription for the preferred product.] _____

Available Formulary Alternatives: bicalutamide, XTANDI, ZYTIGA

2. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Y N

3. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below [If yes, then documentation is required for approval.] Drug Name and Reason for Failure _____	<input type="checkbox"/> Y <input type="checkbox"/> N
<p>Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 3 in a class with 3 alternatives, bicalutamide, XTANDI, ZYTIGA</p>	
[If yes, no further questions.]	
5. Does the patient have a contraindication to all the alternatives?	<input type="checkbox"/> Y <input type="checkbox"/> N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date