Eligard

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:

Please indicate the strength of the product being requested: ❑ 7.5mg ❑ 22.5mg ❑ 30mg ❑ 45mg

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Prostate cancer (*If checked, go to 23*)
❒ Recurrent salivary gland tumors (*If checked, go to 2*)
❒ Gender dysphoria (*If checked, go to 7*)
❒ Other, please specify _____ (*If checked, no further questions*)

2. Is the request for continuation of therapy?

Send completed form to: Priority Partners Fax: 1-866-212-4756

❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

3. Has the patient experienced clinical benefit while receiving the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the tumor androgen receptor positive?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Is the patient less than 18 years of age?
❒ Yes, *Continue to 8*
❒ No, *Continue to 9*

8. Is the requested medication prescribed by, or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the patient able to make an informed decision to engage in treatment?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the request for continuation of therapy?
❒ Yes, *Continue to 18*
❒ No, *Continue to 13*

13. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

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14. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 15*
❒ No, *Continue to 16*

15. Which Tanner stage of puberty has the patient reached?
❒ Tanner stage I (*If checked, no further questions*)
❒ Tanner stage II (*If checked, no further questions*)
❒ Tanner stage III (*If checked, no further questions*)
❒ Tanner stage IV (*If checked, no further questions*)
❒ Tanner stage V (*If checked, no further questions*)
❒ Unknown (*If checked, no further questions*)

16. Is the patient undergoing gender transition?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 20*
❒ No, *Continue to 21*

20. Which Tanner stage of puberty has the patient reached previously?
❒ Tanner stage I (If checked, *no further questions*)
❒ Tanner stage II (If checked, *no further questions*)
❒ Tanner stage III (If checked, *no further questions*)
❒ Tanner stage IV (If checked, *no further questions*)
❒ Tanner stage V (If checked, *no further questions*)
❒ Unknown (If checked, *no further questions*)

21. Is the patient undergoing gender transition?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 24*
❒ No, *No Further Questions*

24. Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

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X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076

Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org.