Fensolvi

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:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Central precocious puberty (CPP), *Continue to 2*

❒ Gender dysphoria, *Continue to 13*

❒ Other, please specify. _____, *No further questions*

2. Is the patient currently receiving the prescribed therapy for central precocious puberty through a paid pharmacy or medical benefit?

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❒ Yes, *Continue to 3*
❒ No, *Continue to 7*

3. Is the patient experiencing signs of treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What is the patient's gender?
❒ Male, *Continue to 5*
❒ Female, *Continue to 6*

5. What is the patient's age?
❒ Less than 13 years of age, *No further questions*
❒ 13 years of age or older, *No further questions*

6. What is the patient's age?
❒ Less than 12 years of age, *No further questions*
❒ 12 years of age or older, *No further questions*

7. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging (e.g., computed tomography (CT) scan, magnetic resonance imaging (MRI))?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third generation luteinizing hormone (LH) assay? ***ACTION REQUIRED***: If Yes, collect laboratory report or medical record of a pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the patient's gender?
❒ Male, *Continue to 11*
❒ Female, *Continue to 12*

11. How old was the patient at the onset of secondary sexual characteristics?
❒ Less than 9 years of age, *No further questions*
❒ 9 years of age or older, *No further questions*

12. How old was the patient at the onset of secondary sexual characteristics?

❒ Less than 8 years of age, *No further questions*

❒ 8 years of age or older, *No further questions*

13. Is the patient less than 18 years of age?

❒ Yes, *Continue to 14*

❒ No, *Continue to 15*

14. Is the requested drug 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 15*

❒ No, *Continue to 15*

15. Are the patient's comorbid conditions reasonably controlled?

❒ Yes, *Continue to 16*

❒ No, *Continue to 16*

16. Is the patient able to make an informed decision to engage in treatment?

❒ Yes, *Continue to 17*

❒ No, *Continue to 17*

17. Has the patient been educated on any contraindications and side effects to therapy?

❒ Yes, *Continue to 18*

❒ No, *Continue to 18*

18. Is the request for continuation of therapy?

❒ Yes, *Continue to 24*

❒ No, *Continue to 19*

19. Has the patient been informed of fertility preservation options?

❒ Yes, *Continue to 20*

❒ No, *Continue to 20*

20. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?

❒ Yes, *Continue to 21*

❒ No, *Continue to 22*

21. Which Tanner Stage of puberty has the patient reached?

❒ Tanner Stage I, *No further questions*

❒ Tanner Stage II, *No further questions*

❒ Tanner Stage III, *No further questions*

❒ Tanner Stage IV, *No further questions*

❒ Tanner Stage V, *No further questions*

❒ Unknown, *No further questions*

22. Is the patient undergoing gender transition?

❒ Yes, *Continue to 23*

❒ No, *Continue to 23*

23. Will the patient receive the requested drug concomitantly with gender-affirming hormones?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

24. Has the patient been informed of fertility preservation options before the start of therapy?

❒ Yes, *Continue to 25*

❒ No, *Continue to 25*

25. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?

❒ Yes, *Continue to 26*

❒ No, *Continue to 27*

26. Which Tanner Stage of puberty has the patient reached previously?

❒ Tanner Stage I, *No further questions*

❒ Tanner Stage II, *No further questions*

❒ Tanner Stage III, *No further questions*

❒ Tanner Stage IV, *No further questions*

❒ Tanner Stage V, *No further questions*

❒ Unknown, *No further questions*

27. Is the patient undergoing gender transition?

❒ Yes, *Continue to 28*

❒ No, *Continue to 28*

28. Will the patient receive the requested drug concomitantly with gender-affirming hormones?

❒ 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.

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

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