Lupron Hormonal Therapy

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:

1. Which drug and strength is being prescribed?

❑ Lupron Depot 7.5 mg
❑ Lupron Depot-3 month 22.5 mg
❑ Lupron Depot-4 month 30 mg
❑ Lupron Depot-6 month 45 mg
❑ Lupron Depot 3.75 mg
❑ Lupron Depot-3 month 11.25 mg
❑ leuprolide kit
❑ leuprolide acetate depot 3-month 22.5 mg
❑ Other _____

❑ Lupron Depot-**PED** 7.5 mg
❑ Lupron Depot-**PED-1 month** 11.25 mg
❑ Lupron Depot-**PED-3 month** 11.25 mg
❑ Lupron Depot-**PED** 15 mg
❑ Lupron Depot-**PED** 30 mg

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Indicate prescribed dose and frequency: _____

2. What is the requested drug being used for?
   - ❑ Uterine leiomyomata (fibroids)
   - ❑ Epithelial ovarian cancer
   - ❑ Ovarian cancer - Malignant sex cord-stromal tumor (granulosa cell tumors)
   - ❑ Endometriosis
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ Primary peritoneal cancer
   - ❑ Fallopian tube cancer
   - ❑ Salivary gland tumors
   - ❑ Grade 1 endometrioid carcinoma
   - ❑ Low-grade serous carcinoma
   - ❑ Mucinous carcinoma of the ovary
   - ❑ Clear cell carcinoma of the ovary
   - ❑ Carcinosarcoma (malignant mixed Müllerian tumors)
   - ❑ Gender dysphoria
   - ❑ Preservation of ovarian function in patients with cancer
   - ❑ Recurrent menstrual related attacks in acute porphyria
   - ❑ Central precocious puberty (CPP)
   - ❑ Other, please specify _____

3. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Central Precocious Puberty

4. Is the patient currently receiving the prescribed therapy for central precocious puberty through a paid pharmacy or medical benefit? ❑ Yes ❑ No *If No, skip to #6*

5. Is the patient experiencing signs of treatment failure (e.g. clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)*?* ❑ Yes ❑ No *No further questions.*

6. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging, such as computed tomography (CT scan), magnetic resonance imaging (MRI)? ❑ Yes ❑ No

7. 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 pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay***. ❑ Yes ❑ No

8. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty? ❑ Yes ❑ No

9. How old was the patient **AT THE ONSET** of secondary sexual characteristics? _____ years

Section B: Uterine leiomyomata (Fibroids)

10. Does the patient have a diagnosis of anemia due to uterine leiomyomata (fibroids) (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10g/dL)? ❑ Yes ❑ No
    Provide at least one lab value and date drawn:
    Hematocrit (Hct): _____ % Date drawn: _____
    Hemoglobin (Hgb): _____ g/dL Date drawn: _____

11. Will requested drug be used prior to surgery for uterine leiomyomata (fibroids)? ❑ Yes ❑ No

12. Has the patient received previous therapy with Lupron Depot? ❑ Yes ❑ No *If No, no further questions*

13. How long has the patient received previous therapy with Lupron Depot? _____ months

Section C: Endometriosis

14. Has the patient received previous therapy with Lupron Depot? ❑ Yes ❑ No *If No, no further questions*

15. Has the patient had a recurrence of symptoms? ❑ Yes ❑ No

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16. Is the patient's bone mineral density within normal limits? ❑ Yes ❑ No

17. How long has the patient received previous therapy with Lupron Depot? _____ months

Section D: Gender Dysphoria

18. Is the patient less than 18 years of age? ❑ Yes ❑ No *If No, skip to #20*

19. 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 care provider? ❑ Yes ❑ No

20. Are the patient's comorbid conditions reasonably controlled? ❑ Yes ❑ No

21. Is the patient able to make an informed decision to engage in treatment? ❑ Yes ❑ No

22. Has the patient been educated on any contraindications and side effects to therapy? ❑ Yes ❑ No

23. Is the request for continuation of therapy? *If Yes, skip to #29* ❑ Yes ❑ No

24. Has the patient been informed of fertility preservation options? ❑ Yes ❑ No

25. Is the requested medication prescribed for pubertal hormonal suppression in an adolescent patient?
❑ Yes ❑ No *If No, skip to #27*

26. Which Tanner Stage of puberty has the patient reached?
❑ Tanner Stage I
❑ Tanner Stage II
❑ Tanner Stage III
❑ Tanner Stage IV
❑ Tanner Stage V
❑ Unknown
No further questions

27. Is the patient undergoing gender transition? ❑ Yes ❑ No

28. Will the patient receive the requested medication concomitantly with gender-affirming hormones?
❑ Yes ❑ No *If Yes or No, no further questions*

29. Has the patient been informed of fertility preservation options before the start of therapy? ❑ Yes ❑ No

30. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❑ Yes ❑ No *If No, skip to #32*

31. Which Tanner Stage of puberty has the patient reached?
❑ Tanner Stage I
❑ Tanner Stage II
❑ Tanner Stage III
❑ Tanner Stage IV
❑ Tanner Stage V
❑ Unknown
No further questions

32. Is the patient undergoing gender transition? ❑ Yes ❑ No

33. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❑ Yes ❑ No *No further questions*

Section E: Salivary Gland Tumors

34. Does the patient have recurrent disease? ❑ Yes ❑ No

35. Is the tumor androgen receptor positive? ❑ Yes ❑ No

36. Is the patient currently receiving treatment with the requested medication?
❑ Yes ❑ No *If No, no further questions*

37. Has the patient experienced an unacceptable toxicity or disease progression while receiving the requested drug?
❑ Yes ❑ No *No further questions*

Section F: Prostate Cancer

38. Is the patient currently receiving treatment with the requested medication?
❑ Yes ❑ No *If No, no further questions*

39. Has the patient experienced clinical benefit to therapy while on the current regimen (e.g., serum testosterone less than 50 ng/dL)? ❑ Yes ❑ No

40. Has the patient experienced an unacceptable toxicity while on the current regimen? ❑ Yes ❑ No

Section G: Breast Cancer

41. What is the patient's hormone receptor (HR) status?
❑ Positive
❑ Negative
❑ Unknown

42. Is the patient currently receiving treatment with the requested medication?
❑ Yes ❑ No *If No, no further questions*

43. Has the patient experienced an unacceptable toxicity or disease progression while receiving the requested drug?
❑ Yes ❑ No

Section H: Preservation of Ovarian Function in Patients with Cancer

44. Is the patient premenopausal and undergoing chemotherapy? ❑ Yes ❑ No

Section I: Prevention of Recurrent Menstrual Related Attacks in Acute Porphyria

45. Is the requested drug being requested to prevent recurrent menstrual related attacks in acute porphyria?
❑ Yes ❑ No

46. Is the requested drug prescribed by, or in consultation with, a physician experienced in the management of porphyrias? ❑ Yes ❑ No

Section J: Ovarian Cancer - Malignant Sex Cord-Stromal Tumor (granulosa cell tumors), Epithelial Ovarian Cancer, Fallopian tube cancer, Primary Peritoneal Cancer, Grade 1 Endometrioid Cancer, Low-grade Serous Carcinoma, Carcinosarcoma (malignant mixed Müllerian tumors), Mucinous Carcinoma of the Ovary, Clear Cell Carcinoma of the Ovary

47. Does the patient have persistent or recurrent disease? ❑ Yes ❑ No

48. Will the requested medication be used as a single agent? ❑ Yes ❑ No

49. Is the patient currently receiving treatment with the requested drug?
❑ Yes ❑ No *If No, no further questions*

50. Has the patient experienced an unacceptable toxicity or disease progression while receiving the requested drug?
❑ Yes ❑ No

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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