Trelstar

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 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 _____

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Prostate cancer, *Continue to 19*
❒ Gender dysphoria, *Continue to 2*
❒ Preservation of ovarian function, *Continue to 18*
❒ Breast cancer - ovarian suppression, *Continue to 22*
❒ Other, please specify _____, *No further questions*

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

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❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. 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 4*
❒ No, *Continue to 4*

4. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the patient able to make an informed decision to engage in treatment?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the request for continuation of therapy?
❒ Yes, *Continue to 13*
❒ No, *Continue to 8*

8. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the requested medication prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 10*
❒ No, *Continue to 11*

10. 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*

11. Is the patient undergoing gender transition?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Will the patient receive the requested medication concomitantly with gender-affirming hormones?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

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 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*

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. Is the patient premenopausal and undergoing chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 20*
❒ No, *No Further Questions*

20. Has the patient experienced clinical benefit to therapy while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Has the patient experienced an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 23*
❒ No, *Continue to 26*

23. Was the patient premenopausal at diagnosis?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the patient still undergoing treatment with endocrine therapy?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. How many years has the patient received therapy with the requested medication?

❒ 5 years or greater, *No further questions*

❒ 4 years, *No further questions*

❒ 3 years, *No further questions*

❒ 2 years, *No further questions*

❒ 1 year or less, *No further questions*

26. Is the patient premenopausal?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. What is the patient's hormone receptor (HR) status? ***ACTION REQUIRED***: Please attach documentation of hormone receptor status testing results.

❒ HR-positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 28*

❒ HR-negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 28*

❒ Unknown, *Continue to 28*

28. Is the patient at higher risk for recurrence (e.g., young age, high-grade tumor, lymph-node involvement)?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Will the requested drug be used in combination with endocrine therapy?
❒ 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 Priority Partners.

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

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