Zoladex

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 dose of the requested drug is being prescribed?

❒ Zoladex 3.6 mg, *Continue to 2*

❒ Zoladex 10.8 mg, *Continue to 3*

2. What is the diagnosis?

❒ Prostate cancer, *Continue to 4*

❒ Breast cancer, *Continue to 4*

❒ Dysfunctional uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only), *Continue to 17*

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 Zoladex with Other Ind SGM 1918-A – 09/2023.

❒ Chronic anovulatory uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only), *Continue to 17*

❒ Endometriosis (3.6 mg dose only), *Continue to 20*

❒ Preservation of ovarian function (3.6 mg dose only), *Continue to 23*

❒ Prevention of recurrent menstrual related attacks in acute porphyria (3.6 mg dose only), *Continue to 40*

❒ Uterine leiomyomata (fibroids) (3.6 mg dose only), *Continue to 21*

❒ Gender dysphoria, *Continue to 24*

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

3. What is the diagnosis?

❒ Prostate cancer, *Continue to 5*

❒ Breast cancer, *Continue to 5*

❒ Gender dysphoria, *Continue to 24*

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

4. Is this a request for continuation of therapy with Zoladex 3.6 mg?
❒ Yes, *Continue to 10*
❒ No, *Continue to 15*

5. Is this a request for continuation of therapy with Zoladex 10.8 mg?
❒ Yes, *Continue to 6*
❒ No, *Continue to 14*

6. What is the diagnosis?

❒ Prostate cancer, *Continue to 7*

❒ Breast cancer, *Continue to 8*

7. Has the patient experienced clinical benefit while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

8. Has the patient experienced clinical benefit while on the current regimen?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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

10. What is the diagnosis?

❒ Prostate cancer, *Continue to 11*

❒ Breast cancer, *Continue to 12*

11. Has the patient experienced clinical benefit while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?

❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

12. Has the patient experienced clinical benefit while on the current regimen?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

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

14. What is the diagnosis?

❒ Prostate cancer, *No further questions*

❒ Breast cancer, *Continue to 16*

15. What is the diagnosis?

❒ Prostate cancer, *No further questions*

❒ Breast cancer, *Continue to 16*

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

❒ HR-positive ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ HR-negative ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

17. Will the requested drug be used as an endometrial thinning agent prior to endometrial ablation or resection for dysfunctional uterine bleeding?
❒ Yes, *No Further Questions*
❒ No, *Continue to 18*

18. Will the requested drug be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. For how many months has the patient already received the requested drug for this indication?

❒ 6 months or greater, *No further questions*

❒ 5 months, *No further questions*

❒ 4 months, *No further questions*

❒ 3 months, *No further questions*

❒ 2 months, *No further questions*

❒ 1 month, *No further questions*

❒ Less than 1 month, *No further questions*

20. For how many months has the patient already received the requested drug for this indication?

❒ 6 months or greater, *No further questions*

❒ 5 months, *No further questions*

❒ 4 months, *No further questions*

❒ 3 months, *No further questions*

❒ 2 months, *No further questions*

❒ 1 month, *No further questions*

❒ Less than 1 month, *No further questions*

21. Will the requested drug be given prior to surgery?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. For how many months has the patient already received the requested drug for this indication?

❒ 3 months or greater, *No further questions*

❒ 2 months, *No further questions*

❒ 1 month, *No further questions*

❒ Less than 1 month, *No further questions*

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

24. Is the patient less than 18 years of age?
❒ Yes, *Continue to 25*
❒ No, *Continue to 26*

25. 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 26*
❒ No, *Continue to 26*

26. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is the patient able to make an informed decision to engage in treatment?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the request for continuation of therapy?
❒ Yes, *Continue to 35*
❒ No, *Continue to 30*

30. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 32*
❒ No, *Continue to 33*

32. 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*

33. Is the patient undergoing gender transition?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

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

35. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 37*
❒ No, *Continue to 38*

37. 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*

38. Is the patient undergoing gender transition?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

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

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

40. Is the requested drug being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
❒ 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)**

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

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