Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

LUPRON & OTHER LHRH AGENTS
Prior Authorization Form

ELIGARD, FIRMAGON, LEUPROLIDE, LUPRON DEPOT, LUPRON DEPOT- PED, SUPPRELIN LA, SYNAREL, TRELSTAR DEPOT, TRELSTAR LA, VANTAS, ZOLADEX

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary	

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

□ **Prostate Cancer**

□ **Breast Cancer**

□ **Endometriosis**	What is the severity of the Endometriosis? □ Mild □ Moderate □ Severe Has the diagnosis been confirmed by laparoscopy? □ Yes □ No *If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis.* Has the member tried oral contraceptives? □ Yes □ No

Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ **Central precocious puberty**	What age did the patient have an onset of secondary sexual characteristics? Age:_____
☐ **Dysfunctional Uterine Bleeding**	Is the member undergoing endometrial ablation? ☐ Yes ☐ No
☐ **Uterine Leiomyomata or fibroids**	Does the member have anemia (Hemoglobin less than 11)? ☐ Yes ☐ No Is the medication being used as a preoperative adjuvant to surgery? ☐ Yes ☐ No *If no, please provide clinical rationale for use.*

Please provide any additional information which should be considered in the space below: