

LUPRON & OTHER LHRH AGENTS Prior Authorization Form

ELIGARD, FIRMAGON, LEUPROLIDE, LUPRON DEPOT, LUPANETA PACK, SYNAREL, TRELSTAR

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- Standard Request (72 hours)
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- Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<input type="checkbox"/> New medication <input type="checkbox"/> 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

<input type="checkbox"/> Billed by PHARMACY dispensed to the member <i>or</i> provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Diagnosis:	Date Diagnosed:
<input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Endometriosis	What is the severity of the Endometriosis? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Has the diagnosis been confirmed by laparoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If NO, please provide chart documentation of an adequate work-up and the clinical rationale for the diagnosis.</i> Has the member tried oral contraceptives and/or progestins? <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Central precocious puberty	What age did the patient have an onset of secondary sexual characteristics? Age: _____
<input type="checkbox"/> F ibroids	Does the member have anemia (Hemoglobin less than 11)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication being used as a preoperative adjuvant to surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;"><i>If no, please provide clinical rationale for use.</i></p>
Please provide any additional information which should be considered in the space below:	