PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Lupron - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Lupron - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Lupron (leuprolide acetate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested medication being used for the treatment of adult males with certain diagnosed behavioral disorder? Y N

[If yes, no further questions.]

2. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.		
	[If no, skip to question 8.]		
3.	Is the requested medication being used for hormone suppression of puberty?	Y N	
	[If no, skip to question 5.]		
4.	Has the patient shown a beneficial response to treatment?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
5.	Does the patient have a diagnosis of precocious puberty?	Y N	
	[If yes, skip to question 7.]		
6.	Does the patient have a diagnosis of advanced prostate cancer?	Y N	
	[If no, no further questions.]		
7.	Has the patient shown a beneficial response to treatment?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
8.	Does the patient have a documented diagnosis of advanced prostate cancer and is Leuprolide being used as a palliative treatment?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, skip to question 11.]		
9.	Does the patient have an inoperable prostate tumor?	Y N	
	[If yes, no further questions.]		
10.	Does the patient refuse to undergo an orchiectomy?	Y N	
	[No further questions.]		
11.	Does the patient have a diagnosis of precocious puberty?	Y N	
	[If no, skip to question 14.]		
12.	Does the patient have a diagnosis of true (central) precocious puberty (defined as sexual maturation less than age 8 in girls and sexual maturation less than age 10 in boys)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
13.	Have tumors been ruled out in the patient by laboratory tests, CT, MRI, or ultrasound?	Y N	
	NOTE: Submission of medical records is required.		
	[No further questions.]		
14.	Will the requested drug be used for hormone suppression of puberty?	Y N	

[If no, no further questions.]	
15. Does the patient have a Tanner stage 2 or above in development?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
16. Does the patient have a diagnosis of gender dysphoria through medical evaluation by a health professional in accordance with MDH guidance, and other applicable JHHC policies?	Y N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date