



Leuprolide Acetate (medical benefit alignment)

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 along with supporting clinical documentation 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 Home Off Campus Outpatient Hospital
- On Campus Outpatient Hospital Office

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un

Directions(sig) _____ Route of administration _____

Dosing frequency _____

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis or the type of procedure the patient will be undergoing?

Ovulation induction (e.g., intrauterine insemination (IUI)), *Continue to #101*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leuprolide SGM 2117-A, Leuprolide (medical benefit alignment) SGM 1989-A - 07/2023.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

Assisted reproductive technology (e.g., in vitro fertilization (IVF), frozen embryo transfer, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI)), *Continue to #101*

Mature oocyte cryopreservation, *Continue to #101*

Embryo cryopreservation, *Continue to #101*

Preimplantation genetic diagnosis, *Continue to #101*

Central precocious puberty (CPP) (including use as a stimulation test to confirm the diagnosis of CPP), *Continue to 2*

Prostate cancer, *Continue to 14*

Treatment of advancing puberty and growth failure, *Continue to 17*

Recurrent salivary gland tumors, *Continue to 19*

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

2. Will the requested drug be used as a stimulation test to confirm the diagnosis of central precocious puberty (CPP)?

Yes, *No Further Questions*

No, *Continue to 3*

3. Is the patient currently receiving the prescribed therapy for central precocious puberty through a paid pharmacy or medical benefit?

Yes, *Continue to 4*

No, *Continue to 8*

4. Is the patient experiencing signs of treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)?

Yes, *No Further Questions*

No, *Continue to 5*

5. What is the patient's gender?

Male, *Continue to 6*

Female, *Continue to 7*

6. What is the patient's age?

Less than 13 years of age, *No further questions*

13 years of age or older, *No further questions*

7. What is the patient's age?

Less than 12 years of age, *No further questions*

12 years of age or older, *No further questions*

8. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging (e.g., computed tomography (CT) scan, magnetic resonance imaging (MRI))?

Yes, *Continue to 9*

No, *Continue to 9*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leuprolide SGM 2117-A, Leuprolide (medical benefit alignment) SGM 1989-A - 07/2023.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

9. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a gonadotropin-releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay? **ACTION REQUIRED:** If Yes, collect laboratory report or medical record of pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 10*
 No, *Continue to 10*

10. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty?

- Yes, *Continue to 11*
 No, *Continue to 11*

11. What is the patient's gender?

- Male, *Continue to 12*
 Female, *Continue to 13*

12. How old was the patient at the onset of secondary sexual characteristics?

- Less than 9 years of age, *No further questions*
 9 years of age or older, *No further questions*

13. How old was the patient at the onset of secondary sexual characteristics?

- Less than 8 years of age, *No further questions*
 8 years of age or older, *No further questions*

14. Is the patient currently receiving treatment with the requested drug?

- Yes, *Continue to 15*
 No, *No Further Questions*

15. Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)?

- Yes, *Continue to 16*
 No, *Continue to 16*

16. Has the patient experienced an unacceptable toxicity while receiving the requested drug?

- Yes, *No Further Questions*
 No, *No Further Questions*

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

- Yes, *Continue to 18*
 No, *Continue to 18*

18. Is the patient also requesting or is currently receiving growth hormone?

- Yes, *No Further Questions*
 No, *No Further Questions*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leuprolide SGM 2117-A, Leuprolide (medical benefit alignment) SGM 1989-A - 07/2023.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

19. Is the patient currently receiving treatment with the requested drug?

- Yes, *Continue to 20*
 No, *Continue to 22*

20. Has the patient experienced clinical benefit to therapy while on the current regimen?

- 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 tumor androgen receptor positive?

- Yes, *Continue to 23*
 No, *Continue to 23*

23. Will the requested drug be used as a single agent?

- Yes, *No Further Questions*
 No, *No Further Questions*

101. Is coverage for the drug being requested for a procedure that has been approved by the patient's medical benefit plan?

- Yes, *Continue to #102*
 No, *Continue to #104*

102. Has the medical authorization number been provided? Please indicate: _____

- Yes, *Continue to #103*
 No, *Continue to #104*
 Not applicable, patient's medical benefit plan does not require precertification for the requested procedure, *Continue to #103*

103. Please indicate the type of procedure that has been approved by the medical benefit plan:

- Ovulation induction (e.g., intrauterine insemination [IUI]), *No Further Questions*
 Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete, *No Further Questions* intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI])
 Mature oocyte cryopreservation, *No Further Questions*
 Embryo cryopreservation, *No Further Questions*
 Preimplantation genetic diagnosis, *No Further Questions*

104. What is the type of procedure the patient will be undergoing?

- Ovulation induction (e.g., intrauterine insemination [IUI]), *Continue to #105*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leuprolide SGM 2117-A, Leuprolide (medical benefit alignment) SGM 1989-A - 07/2023.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI]), *Continue to #105*

Other, *Continue to #105*

105. What is the intent of therapy?

Inhibition of premature luteinizing hormone (LH) surge, *No Further Questions*

Trigger of oocyte maturation and ovulation, *No Further Questions*

Other, *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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leuprolide SGM 2117-A, Leuprolide (medical benefit alignment) SGM 1989-A - 07/2023.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com