Eligard

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*_____

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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. Please indicate the strength being requested: ❑ 7.5mg ❑ 22.5mg ❑ 30mg ❑ 45mg
2. What is the ICD-10 code? _____
3. What is the diagnosis?
   ❑ Prostate cancer ❑ Gender dysphoria
   ❑ Recurrent salivary gland tumors ❑ Other _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Gender Dysphoria

4. Is Eligard prescribed for pubertal hormonal suppression in an adolescent patient?
   ❑ Yes ❑ No *If No, skip to #6*
5. Which Tanner Stage of puberty has the patient reached? ***Indicate below and no further questions***
   ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions*
6. Is the patient undergoing gender transition? ❑ Yes ❑ No
7. Will the patient receive Eligard concomitantly with gender-affirming hormones? ❑ Yes ❑ No

Section B: Recurrent Salivary Gland Tumors

8. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #11*
9. Has the patient experienced clinical benefit while receiving the requested drug? ❑ Yes ❑ No
10. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
    ❑ Yes ❑ No *No further questions*
11. Is the tumor androgen receptor positive? ❑ Yes ❑ No

Section C: Prostate cancer

12. Is the patient currently receiving treatment with the requested medication?
    ❑ Yes ❑ No *If No, no further questions*
13. Has the patient experienced clinical benefit while receiving the requested drug? (e.g., serum testosterone less than 50 ng/dL)? ❑ Yes ❑ No
14. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
    ❑ Yes ❑ No

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)**

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