Leuprolide Acetate

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. What is the requested drug being used for?
   - ❑ Ovulation induction (e.g., intrauterine insemination [IUI])
   - ❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT])
   - ❑ Central precocious puberty (CPP) (including use as a stimulation test to confirm diagnosis of CPP)
   - ❑ Prostate cancer
   - ❑ Treatment of advancing puberty and growth failure
   - ❑ Recurrent salivary gland tumors
   - ❑ Other

2. What is the ICD-10 code? _____

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

Section A: Central Precocious Puberty

3. Is leuprolide being requested for use as a stimulation test to confirm diagnosis of CPP?
   If Yes, no further questions ❑ Yes ❑ No

4. Is the patient currently receiving the prescribed therapy for central precocious puberty through a paid pharmacy or medical benefit? ❑ Yes ❑ No *If no, skip to #6*

5. Is the patient experiencing signs of treatment failure such as clinical pubertal progression, lack of growth deceleration and continued excessive bone age advancement? ❑ Yes ❑ No *No further questions*

6. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging, such as computed tomography (CT scan), magnetic resonance imaging (MRI), or ultrasound? ❑ Yes ❑ No

7. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a GnRH (gonadotropin-releasing hormone) agonist test **or** a pubertal level of a third-generation LH (luteinizing hormone) 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.*** ❑ Yes ❑ No

8. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty? ❑ Yes ❑ No

9. How old was the patient **AT THE ONSET** of secondary sexual characteristics? _____ years

Section B: Prostate Cancer, and Recurrent Salivary Gland Tumors

10. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No
    For recurrent salivary gland tumors requests: *If No, skip to #14*
    For Prostate Cancer: *If No, no further questions.*

11. Has the patient experienced clinical benefit while receiving the requested drug? ❑ Yes ❑ No

12. Has the patient experienced an unacceptable toxicity while receiving the requested drug? ❑ Yes ❑ No *No further questions*

13. *If the diagnosis is recurrent salivary gland tumors,* is the tumor androgen receptor positive? ❑ Yes ❑ No

Section C: Advancing puberty and growth failure

14. Is the patient also requesting or is currently receiving growth hormone? ❑ Yes ❑ No

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Section D: Infertility; Ovulation induction (e.g., intrauterine insemination [IUI]), Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT])

15. Is coverage for the drug being requested for a procedure that has been approved by the patient's medical benefit plan? ❑ Yes ❑ No *If No, skip to #18*

16. Has the medical authorization number been provided?
    - ❑ Yes, please indicate: _____
    - ❑ No, s*kip to #18*
    - ❑ Not applicable, patient's medical benefit plan does not require precertification for the requested procedure

17. Please indicate the type of procedure that has been approved by the medical benefit plan: *No further questions*
    - ❑ Ovulation induction (e.g., intrauterine insemination [IUI])
    - ❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI])
    - ❑ Mature oocyte cryopreservation
    - ❑ Embryo cryopreservation
    - ❑ Preimplantation genetic diagnosis

18. What is the type of procedure the patient will be undergoing?
    - ❑ Ovulation induction (e.g., intrauterine insemination [IUI])
    - ❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI])
    - ❑ Other

19. What is the intent of therapy?
    - ❑ Inhibition of premature luteinizing hormone (LH) surge
    - ❑ Ovulation trigger
    - ❑ Other

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)**

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