Lupron Hormonal Therapy

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

 Lupron Hormonal Other Ind SGM – 10/2021.

Criteria Questions:

1. Which drug and strength is being prescribed?
   - ❑ Lupron Depot 7.5 mg
   - ❑ Lupron Depot-3 month 22.5 mg
   - ❑ Lupron Depot-4 month 30 mg
   - ❑ Lupron Depot-6 month 45 mg
   - ❑ Lupron Depot 3.75 mg
   - ❑ Lupron Depot-3 month 11.25 mg
   - ❑ leuprolide kit
   - ❑ Other _____
   - ❑ Lupron Depot-**PED** 7.5 mg
   - ❑ Lupron Depot-**PED-1 month** 11.25 mg
   - ❑ Lupron Depot-**PED-3 month** 11.25 mg
   - ❑ Lupron Depot-**PED** 15 mg
   - ❑ Lupron Depot-**PED** 30 mg
   - ❑ Lupaneta Pack

   Indicate prescribed dose and frequency: _____

2. What is the requested drug being used for?
   - ❑ Uterine fibroids
   - ❑ Endometriosis
   - ❑ Prostate cancer
   - ❑ Fallopian tube cancer
   - ❑ Central precocious puberty (CPP)
   - ❑ Preservation of ovarian function
   - ❑ Recurrent menstrual related attacks in acute porphyria
   - ❑ Other _____
   - ❑ Epithelial ovarian cancer
   - ❑ Breast cancer
   - ❑ Primary peritoneal cancer
   - ❑ Malignant sex cord-stromal tumor
   - ❑ Recurrent salivary gland tumors
   - ❑ Gender dysphoria

3. What is the ICD-10 code? _____

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

Section A: Central Precocious Puberty

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: Uterine Fibroids

10. Has the patient received previous therapy with Lupron Depot or Lupaneta Pack? ❑ Yes ❑ No *If No, skip to #12*

11. How long has the patient received prior therapy with Lupron Depot and Lupaneta Pack? _____ months

    Indicate dates and doses received: _____

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12. Does the patient have a diagnosis of anemia? ❑ Yes ❑ No
    Provide at least one lab value and date drawn:
    Hematocrit (Hct): _____ % Date drawn: _____
    Hemoglobin (Hgb): _____ g/dL Date drawn: _____

13. Will prescribed agent be used prior to surgery for uterine fibroids? ❑ Yes ❑ No

Section C: Endometriosis

14. Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
    ❑ Yes ❑ No *If No, no further questions*

15. Has the patient had a recurrence of symptoms? ❑ Yes ❑ No

16. Is the patient's bone mineral density within normal limits? ❑ Yes ❑ No

17. How long has the patient received previous therapy with Lupron Depot and Lupaneta Pack? _____ months
    Indicate dates and doses received: _____

Section D: Gender Dysphoria

18. Is prescribed agent prescribed for pubertal hormonal suppression in an adolescent patient?
    ❑ Yes ❑ No *If No, skip to #20*

19. Which Tanner Stage of puberty has the patient reached?
    ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions*

20. Is the patient undergoing gender transition? ❑ Yes ❑ No

21. Will the patient receive prescribed agent concomitantly with gender-affirming hormones? ❑ Yes ❑ No

Section E: Epithelial Ovarian Cancer, Fallopian Tube Cancer, Malignant Sex Cord-Stromal Tumor, Primary Peritoneal Cancer, Prostate Cancer, and Recurrent Salivary Gland Tumors

22. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No
    For recurrent salivary gland tumors requests: *If No, skip to #25*
    For all other diagnoses: *If No, no further questions.*

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

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

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

Section F: Breast Cancer

26. What is the patient's hormone receptor (HR) status? ❑ Positive ❑ Negative ❑ Unknown

27. Is the patient currently receiving treatment with the requested medication?
    ❑ Yes ❑ No *If No, no further questions.*

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

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

Section G: Preservation of Ovarian Function

30. Is the patient premenopausal and undergoing chemotherapy? ❑ Yes ❑ No

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Section H: Prevention of Recurrent Menstrual Related Attacks in Acute Porphyria

31. Is Lupron Depot being requested to prevent recurrent menstrual related attacks in acute porphyria?
    ❑ Yes ❑ No

32. Is Lupron Depot prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
    ❑ Yes ❑ No

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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