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Lupron Depot – Adult Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Lupron Depot - Adult	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for Lupron Depot (leuprolide acetate). Payment will be considered for patients under the following conditions:
1) Patient meets the FDA approved age; and
2) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and
3) Patient has a diagnosis of endometriosis for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of hormonal contraceptive has failed; or
4) Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or
5) Patient has a diagnosis of advanced prostate cancer.

Therapy will be limited as follows:

- **Endometriosis** – initial 6 month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course.
- **Uterine leiomyomata** – 3 month approval.
- **Advanced prostate cancer** – initial 6 month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

Setting to be administered:

□ Member's home by home health □ Long-term care facility □ Other: _____

□ **Endometriosis**. Payment will be considered for patients for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of hormonal contraceptive has failed.

NSAID trial: Drug name/dose: _____

Trial dates: _____Reason for failure: _____

Continuous hormonal contraceptive trial: Drug name/dose: _____

Trial dates: _____Reason for failure: _____

Renewal requests only:

Will member be prescribed concomitant norethindrone acetate 5mg daily? □ No □ Yes

□ **Uterine Leiomyomata**. Payment will be considered for patients with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively.

Iron trial: Drug name/dose: _____

Trial dates: _____Reason for failure: _____

Most recent Hematocrit Level: Date this level was obtained: _____

Most recent Hemoglobin Level: Date this level was obtained: _____

Is Lupron Depot to be used preoperatively? □ No □ Yes

□ **Advanced Prostate Cancer**

Renewal requests only:

Most recent Testosterone Level (attach results): _____

Date this level was obtained: _____

□ **Other Diagnosis** _____

Possible drug interactions/conflicting drug therapies/other medical conditions to consider: _____

_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____	_____
Prescriber or authorized signature	Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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