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Lupron Depot — Pediatric 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 at 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**
________________	________________	________________	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 — Pediatric. Payment will be considered for patients when the following is met:

1. Patient has a diagnosis of central precocious puberty (CPP).
2. Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males.
3. Patient is currently < 11 years of age for females or < 12 years of age for males.
4. Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results).
5. Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean).
6. Baseline evaluations including the following have been conducted and/or evaluated:
    a. Height and weight measurements
    b. Sex steroid (testosterone or estradiol) levels have been obtained

   c. Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor
   d. Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors
   e. Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor
   f. Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia
7. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

When criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted at 6 month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

Preferred	**Nonpreferred**
☐ Lupron Depot-Ped (1-Month)	☐ Lupron Depot-Ped (3-Month)

Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males? ☐ No ☐ Yes — provide age of onset and description:____

Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test?
☐ No ☐ Yes (attach results)

Documentation of advanced bone age (defined as ≥ two standard deviations above the gender/age related
☐ No ☐ Yes (attach results)

Baseline evaluations:
Height:_________________ Date obtained:_______________________
Weight:_________________ Date obtained: ______________________

Sex steroid (testosterone/estradiol) levels obtained? ☐ No ☐ Yes (attach results)

Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor?
☐ No ☐ Yes (attach results)

Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors?
☐ No ☐ Yes (attach results)

Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor?
☐ No ☐ Yes (attach results)

Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia?
☐ No ☐ Yes (attach results)

Setting to be administered:
☐ Member's home by home health ☐ Long-term care facility ☐ Other

Age override consideration:

Documentation of medical necessity for continued treatment beyond the following ages:
females ≥ 11 years of age and males ≥ 12 years of age: ____
____

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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