Leuprolide Hormonal Therapy

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

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
   - ❑ Eligard 1 month 7.5mg
   - ❑ Eligard 3 month 22.5mg
   - ❑ Eligard 4 month 30mg
   - ❑ Eligard 6 month 45mg
   - ❑ Other _____
   - ❑ Lupron Depot-**PED** 7.5 mg
   - ❑ Lupron Depot-**PED** 11.25 mg
   - ❑ Lupron Depot-**PED** 15 mg
   - ❑ Lupron Depot-**PED** 30 mg
   - ❑ Lupaneta Pack
   - ❑ leuprolide kit

   Indicate prescribed dose and frequency: _____

2. What is the requested drug being used for?
   - ❑ Uterine leiomyomata (fibroids)
   - ❑ Endometriosis
   - ❑ Prostate cancer
   - ❑ Fallopian tube cancer
   - ❑ Central precocious puberty (CPP)
   - ❑ Other _____
   - ❑ Epithelial ovarian cancer
   - ❑ Breast cancer
   - ❑ Primary peritoneal cancer
   - ❑ Malignant sex cord-stromal tumor
   - ❑ 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. 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?
   ❑ Yes ❑ No

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

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

Section B: Uterine Leiomyomata (Fibroids)

7. Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
   ❑ Yes ❑ No *If No, skip to #9*

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

9. Does the patient have a diagnosis of anemia? *If Yes, no further questions* ❑ Yes ❑ No

10. Will prescribed agent be used prior to surgery for uterine leiomyomata (fibroids)? ❑ Yes ❑ No

Section C: Endometriosis

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

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

Section D: Gender Dysphoria

13. What is the patient's physical developmental stage?
    ❑ Patient has NOT completed puberty ❑ Patient has completed puberty, *skip to #16*

14. Is prescribed agent prescribed for pubertal suppression in preparation for gender reassignment (male to female)?
❑ Yes ❑ No

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

16. Is the patient undergoing gender reassignment? ❑ Yes ❑ No

17. Will the patient receive prescribed agent concomitantly with cross sex hormones? ❑ Yes ❑ No

Section E: Breast Cancer

18. Is the prescribed agent prescribed for ovarian suppression in a premenopausal woman? ❑ Yes ❑ No

Section F: Prostate Cancer

19. Will the prescribed agent be used for palliative treatment of advanced prostate cancer? ❑ 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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