Lupron Hormonal Therapy

Prior Authorization Request

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

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 **1-866-814-5506.** 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*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. Which drug and strength is being prescribed? ***Indicate prescribed dose and frequency:*** _____
   - ❑ 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
   - ❑ 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 acetate
   - ❑ Other _____

2. What is the diagnosis or the type of procedure the patient will be undergoing?
   - ❑ Uterine fibroids
   - ❑ Endometriosis
   - ❑ Prostate cancer
   - ❑ Fallopian tube cancer
   - ❑ Central precocious puberty (CPP)
   - ❑ Epithelial ovarian cancer
   - ❑ Breast cancer
   - ❑ Primary peritoneal cancer
   - ❑ Malignant sex cord-stromal tumor
   - ❑ Gender dysphoria
   - ❑ Use as stimulation test to confirm diagnosis of central precocious puberty (CPP)
   - ❑ Treatment of advancing puberty and growth failure
   - ❑ Ovulation induction (eg, intrauterine insemination [IUI])
   - ❑ Assisted reproductive technology (eg, in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT])
   - ❑ Other _____

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?
   If Yes, no further questions ❑ Yes ❑ No

5. 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
6. Has the diagnosis been confirmed by assessment of bone age versus chronological age? ❑ Yes ❑ No

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

Section B: Uterine Fibroids

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

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

   Indicate dates and doses received: _____

10. 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: _____

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

Section C: Endometriosis

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

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

Indicate dates and doses received: _____

Section D: Treatment of Advancing Puberty and Growth Failure

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

Section E: Gender Dysphoria

15. What is the patient's physical developmental stage?
    - ❑ Patient has NOT completed puberty
    - ❑ Patient has completed puberty, *skip to #18*

16. Is prescribed agent prescribed for pubertal suppression in preparation for gender reassignment? ❑ Yes ❑ No

17. Which Tanner Stage of puberty has the patient reached? ***Indicate below and no further questions.***
    ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown

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

19. Will the patient receive prescribed agent concomitantly with cross sex hormones? ❑ 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)**