



Lupron 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.

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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 Pharmacy

Exception Criteria Questions:

- A. Is the product being requested for the treatment of prostate cancer?
 Yes No *If No, skip to Clinical Criteria Questions*
- B. The preferred products for your patient's health plan are Eligard and Firmagon. Can the patient's treatment be switched to a preferred product?
If Yes, please obtain Form for preferred product and submit for corresponding PA. Yes No
- C. Does the patient have a documented hypersensitivity to both of the preferred products (Eligard and Firmagon)?
ACTION REQUIRED: If Yes, please attach supporting chart note(s). Yes No

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

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
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Criteria Questions:

1. Which drug and strength is being prescribed?
- | | |
|--|--|
| <input type="checkbox"/> Lupron Depot 7.5 mg | <input type="checkbox"/> Lupron Depot- PED 7.5 mg |
| <input type="checkbox"/> Lupron Depot-3 month 22.5 mg | <input type="checkbox"/> Lupron Depot- PED-1 month 11.25 mg |
| <input type="checkbox"/> Lupron Depot-4 month 30 mg | <input type="checkbox"/> Lupron Depot- PED-3 month 11.25 mg |
| <input type="checkbox"/> Lupron Depot-6 month 45 mg | <input type="checkbox"/> Lupron Depot- PED 15 mg |
| <input type="checkbox"/> Lupron Depot 3.75 mg | <input type="checkbox"/> Lupron Depot- PED 30 mg |
| <input type="checkbox"/> Lupron Depot-3 month 11.25 mg | <input type="checkbox"/> Lupaneta Pack |
| <input type="checkbox"/> leuprolide kit | |
| <input type="checkbox"/> Other _____ | |

Indicate prescribed dose and frequency: _____

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

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

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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

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

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Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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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