PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Lupron Depot® & Lupron Depot-Ped®
Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Central precocious puberty (CPP) - idiopathic or neurogenic (pediatric formulation only)
❑ Endometriosis (Lupron Depot 3.75 mg and 11.25 mg strengths only)
❑ Gender identity disorder
❑ Prostate cancer (Lupron Depot 7.5 mg, 22.5 mg, 30 mg and 40 mg strengths only)
❑ Uterine Leiomyomata (fibroids) (Lupron Depot 3.75 mg and 11.25 mg strengths only)
❑ Other diagnosis:_____ICD-10 Code(s): _____

For central precocious puberty, answer the following:

Did the onset of early secondary sexual characteristics occur in the patient at < 8 years of age if female or < 9 years of age if male? ❑ **Yes** ❑ **No**

Does the patient have advanced bone age of at least one year compared with chronological age? ❑ **Yes** ❑ **No**

Has the patient undergone gonadotropin-releasing hormone agonist (GnRHa) testing? ❑ **Yes** ❑ **No**

Does the patient have a peak luteinizing hormone (LH) level above pre-pubertal range? ❑ **Yes** ❑ **No**

Does the patient have a random LH level in pubertal range? ❑ **Yes** ❑ **No**

Does the patient have suspected tumors? ❑ **Yes** ❑ **No**

Select if the patient has had the following diagnostic evaluations to rule out tumors, when suspected:

- ❑ Diagnostic imaging of the brain (MRI or CT scan) (in patients with symptoms suggestive of brain tumor or in those 6 years of age or younger
- ❑ Pelvic/testicular/adrenal ultrasound (if steroid levels suggest suspicion)
- ❑ Adrenal steroids to rule out congenital adrenal hyperplasia (when pubarche precedes thelarche or gonadarche)

Is Lupron Depot-Ped prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

Reauthorization:

Have the patient's LH levels been suppressed to pre-pubertal levels? ❑ **Yes** ❑ **No**

Is Lupron Depot-Ped prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

For prostate cancer, answer the following:

Does the patient have advanced or metastatic disease? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on therapy? ❑ **Yes** ❑ **No**

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For endometriosis, answer the following:

Select if the patient has history of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to the following:

- ❑ Danazol
- ❑ Combination (estrogen/progesterone) oral contraceptive
- ❑ Progestins

Has the patient had surgical ablation to prevent recurrence? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have recurrence of symptoms following a trial of at least 6 months with leuprolide acetate? ❑ **Yes** ❑ **No**

Will Lupron Depot be used in combination with norethindrone 5 mg daily, other "add-back" sex-hormones, or other bone-sparing agents? ❑ **Yes** ❑ **No**

For gender identity disorder, answer the following:

Is the patient using Lupron Depot/Lupron Depot-Ped for suppression of puberty? ❑ **Yes** ❑ **No**

Does the patient have demonstrable knowledge of what Lupron Depot/Lupron Depot-Ped medically can and cannot do and their social benefits and risks? ❑ **Yes** ❑ **No**

Is there documentation the patient has had real-life experience (living as the other gender) for at least 3 months prior to the administration of Lupron Depot/Lupron Depot-Ped? ❑ **Yes** ❑ **No**

Has the patient had a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of 3 months)? ❑ **Yes** ❑ **No**

Does the patient have characteristics that meet the definition of gender identity disorder (see characteristics listed below)? ❑ **Yes** ❑ **No**

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
- The disturbance is not concurrent with a physical intersex condition
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The transsexual identity has been present persistently for at least two years
- The disorder is not a symptom of another mental disorder or chromosomal abnormality

For uterine leiomyomata (fibroids), answer the following:

Is Lupron Depot being used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)? ❑ **Yes** ❑ **No**

Is Lupron Depot being used for the treatment of anemia? ❑ **Yes** ❑ **No**

Is the anemia caused by uterine leiomyomata (fibroids)? ❑ **Yes** ❑ **No**

Has the patient tried and had an inadequate response to at least 1 month of monotherapy with iron? ❑ **Yes** ❑ **No**

Will Lupron Depot be used in combination with iron therapy? ❑ **Yes** ❑ **No**

Is Lupron Depot being used prior to surgery? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	