Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Gonadotropin Releasing Hormone Analogs
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information						
Preferred Agent:	☐ Orilissa					
Non-Preferred Agents:	☐ Firmagon	☐ Leuprolide acetate	☐ Lupaneta Pack	☐ Lupron Depot	☐ Lupron Depot-PED	☐ Supprelin LA
	☐ Synarel	☐ Eligard	☐ Trelstar	☐ Triptodur	☐ Vantas	☐ Zoladex
☐ Other, please specify:						

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis?	Are there any contraindications to formulary medications? (if yes, specify):	☐ Yes ☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
☐ **Endometriosis**					
Was there trial AND failure with ONE formulary hormonal cycle control agent OR medroxyprogesterone, in COMBO with NSAID?	☐ Yes	☐ No	Does member have severe disease OR recurrent symptoms?	☐ Yes	☐ No
☐ **Renewal ONLY:**					
Treatment is for recurrence after initial course of therapy?	☐ Yes	☐ No	Total duration of treatment for both initial AND recurrent symptoms will not be longer than 12	☐ Yes	☐ No

			months?		
Will add-back therapy with norethindrone be used concurrently?				☐ Yes	☐ No
☐ **Uterine Leiomyoma - Fibroids**					
Is requested medication prescribed to improve anemia AND/OR reduce uterine size prior to planned surgical intervention?	☐ Yes	☐ No	Was there trial AND failure with iron to correct anemia?	☐ Yes	☐ No
☐ **Endometrial Thinning for Dysfunctional Uterine Bleeding**					
Is requested medication prescribed to thin endometrium prior to planned endometrial ablation OR hysterectomy within next 4-8 weeks?				☐ Yes	☐ No
☐ **Central Precocious Puberty**					
Was an MRI OR CT Scan performed to rule out brain lesions OR tumors?	☐ Yes	☐ No	Does member have onset of secondary sexual characteristics earlier than 8 years in females AND 9 years in males?	☐ Yes	☐ No
Was there response to GnRH stimulation test (or other labs to support CPP, such as LH level, estradiol AND testosterone level)?	☐ Yes	☐ No	Was bone age advanced 1 year beyond chronological age?	☐ Yes	☐ No
☐ **Renewal ONLY**					
Was there clinical response to treatment (for example, pubertal slowing or decline, height velocity, bone age, estradiol AND testosterone level)?				☐ Yes	☐ No
☐ **Advanced Breast Cancer**					
Is member at least 18 years of age AND premenopausal at time of diagnosis?				☐ Yes	☐ No
☐ **Advanced Ovarian Cancer**					
Member cannot tolerate OR does not respond to cytotoxic regimens?	☐ Yes	☐ No	Is drug requested being used for post-operative management?	☐ Yes	☐ No
☐ **Salivary Gland Cancer**					
Does member have androgen receptor positive recurrent disease with distant metastases?	☐ Yes	☐ No	Is there a performance status score of 0 – 3 by ECOG standards?	☐ Yes	☐ No
☐ **Gender Dysphoria/Gender Incongruence in adolescents**					
Was medication prescribed by Pediatric Endocrinologist that collaborated care with a Mental Health Provider?	☐ Yes	☐ No	Does member show persistent, well-documented diagnosis of gender non-conformity OR dysphoria that worsened with puberty?	☐ Yes	☐ No
Does member exhibit signs of puberty with minimum Tanner stage 2?	☐ Yes	☐ No	Has member made a fully informed decision AND given consent, AND parent/guardian consents to treatment OR member has been emancipated?	☐ Yes	☐ No
Are member's comorbid conditions reasonably controlled?	☐ Yes	☐ No	Was member educated on any contraindications AND side effects to therapy?	☐ Yes	☐ No
Was member informed of fertility preservation options prior to treatment?				☐ Yes	☐ No
☐ **Renewal ONLY:**					
Are there lab results to support response to treatment (for example, FSH, LH, weight, height, tanner stage, bone age)?				☐ Yes	☐ No
☐ **Gender Dysphoria/Gender Incongruence in Adults**					
Was requested medication prescribed by Endocrinologist that collaborated care with a Mental Health Provider?	☐ Yes	☐ No	Does member show persistent, well-documented diagnosis of gender dysphoria / incongruence?	☐ Yes	☐ No
Does member have capacity to make a fully informed decision and consents to treatment?	☐ Yes	☐ No	Are mental health concerns, if present, reasonably well controlled?	☐ Yes	☐ No
Was member informed of fertility preservation options prior to treatment?				☐ Yes	☐ No
☐ **Renewal ONLY**					
Are there lab results to support response to treatment (for example, FSH, LH, weight, height, tanner stage, bone age)?				☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.