aetna®

MEDICARE FORM

Lupron Depot® (leuprolide acetate for depot suspension) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Lupron Depot is non-preferred. The preferred product is Eligard. Firmagon is also a preferred product.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Endocrinologist** ☐ **Gynecologist** ☐ **Oncologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: Lupron Depot (leuprolide acetate for depot suspension) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ **Yes** ☐ **No** **Is this request for Lupron Depot-PED?**
→ **Please use the Lupron Depot-PED form for this request.**

For gender dysphoria, malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only:

Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **7.5 mg** ☐ **11.25 mg** ☐ **22.5 mg** ☐ **30 mg** ☐ **45 mg**

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested drug being prescribed for pubertal hormonal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive the requested drug concomitantly with gender-affirming hormones?
→ Indicate the Tanner Stage of puberty the patient has reached: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

☐ **Malignant sex cord-stromal tumors**

☐ **Prostate cancer**

Note: Lupron Depot is non-preferred. The preferred product is Eligard. Firmagon is also a preferred product.

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to Eligard?

Please explain if there are any other medical reason(s) that the patient cannot use Eligard when indicated for the patient's diagnosis?

_____

Continued on next page

aetna®

MEDICARE FORM

Lupron Depot® (leuprolide acetate for depot suspension) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Lupron Depot is non-preferred. The preferred product is Eligard. Firmagon is also a preferred product.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Recurrent salivary gland tumors**
☐ Yes ☐ No Is the tumor androgen receptor positive?

***For breast cancer, endometriosis, ovarian cancer, preservation of ovarian function, recurrent menstrual related attacks in acute porphyria or uterine leiomyomata (fibroids) indication only*:**

Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **11.25 mg**

☐ **Breast cancer**
Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown

☐ **Endometriosis**

☐ **Ovarian cancer**
Please select: ☐ Epithelial ovarian cancer ☐ Fallopian tube cancer ☐ Primary peritoneal cancer ☐ Malignant sex cord-stromal tumor

☐ **Preservation of ovarian function**
☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
☐ Yes ☐ No Is the requested drug being requested to prevent recurrent menstrual related attacks in acute porphyria?
☐ Yes ☐ No Is the requested drug being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?

☐ **Uterine leiomyomata (fibroids)**
☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10 g/dL)?
→ ☐ Yes ☐ No Will the requested drug be used prior to surgery for uterine fibroids?

For Continuation Requests (clinical documentation required for all requests):
For gender dysphoria, malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors continuation requests only:

Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **7.5 mg** ☐ **11.25 mg** ☐ **22.5 mg** ☐ **30 mg** ☐ **45 mg**

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested drug being prescribed for pubertal hormonal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive the requested drug concomitantly with gender-affirming hormones?
→ Indicate the Tanner Stage of puberty the patient has reached: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

☐ **Malignant sex cord-stromal tumors**
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity or disease progression while receiving the requested drug?

☐ **Prostate cancer**
☐ Yes ☐ No Has the patient had prior therapy with Lupron Depot within the last 365 days?
☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50ng/dl)?
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Recurrent salivary gland tumors**
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity or disease progression while receiving the requested drug?

Continued on next page

aetna®

MEDICARE FORM

Lupron Depot® (leuprolide acetate for depot suspension) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: Lupron Depot is non-preferred. The preferred product is Eligard. Firmagon is also a preferred product.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

***For breast cancer, endometriosis, ovarian cancer, preservation of ovarian function, recurrent menstrual related attacks in acute porphyria or uterine fibroids continuation requests only*:**

Please select Lupron Depot dose for the following indications: ☐ **3.75 mg** ☐ **11.25 mg**

☐ **Breast cancer**
- Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Endometriosis**
- ☐ Yes ☐ No Has the patient received previous therapy with the requested medication or Lupaneta Pack?
  - → ☐ Yes ☐ No Has the patient had a recurrence of symptoms?
  - ☐ Yes ☐ No Is the patient's bone mineral density within normal limits?
  - How long has the patient received previous therapy with the requested drug and Lupaneta Pack? _____ months

☐ **Ovarian cancer**
- Please select: ☐ Epithelial ovarian cancer ☐ Fallopian tube cancer ☐ Primary peritoneal cancer ☐ Malignant sex cord-stromal tumor
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Preservation of ovarian function**
- ☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
- ☐ Yes ☐ No Is the requested medication being requested to prevent recurrent menstrual related attacks in acute porphyria?
- ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?

☐ **Uterine leiomyomata (fibroids)**
- ☐ Yes ☐ No Has the patient received previous therapy with the requested drug or Lupaneta Pack?
  - → ☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10g/dL)?
  - How long has the patient received previous therapy with the requested drug and Lupaneta Pack? _____ months
  - → ☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10g/dL)?
    - → ☐ Yes ☐ No Will the requested drug be used prior to surgery for uterine fibroids?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.