

MEDICARE FORM

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

Page 1 of 3

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

For Illinois MMP: FAX: 1-855-320-8445 PHONE: 1-866-600-2139 For other lines of business:

Please use other form.

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

preferred product.

Address:	Please indicate: Start of treatment: Start date/								
Last Name:	 -		therapy, Date o	of last treatment	,				
Last Name:		<u> </u>			Phone	e:	Fax: _		
Address:	A. PATIENT INFORM	ATION					4		
Cell Phone:	First Name:			1					
Patient Current Weight: bs or kgs Patient Height: inches or cms Allergies:	Address:				-		State:	ZIP:	
Authan Member ID #:	Home Phone:		Work Phone:	[(Cell Phone:	1	Email:		
Does patient have other coverage? Yes No	Patient Current Weight:	:Ibs or _	kgs Patie	nt Height:inches	orcms	Allergies:			
	B. INSURANCE INFO	RMATION							
	Aetna Member ID #: _			Does patient have other coverage? ☐ Yes ☐ No					
Medicare: Yes No If yes, provide D #: Medicard: Yes No If yes, provide D #: PRESCRIBER INFORMATION 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: DISPENSING PROVIDER/ADMINISTRATION INFORMATION Place of Administration: Dispensing Provider/Pharmacy: Patient Selected choice Physician's Office Retail Pharmacy Other Center Name: Address: Specialty Pharmacy Other Administration code(s) (CPT): City: State: ZIP: Address: Address: City: State: ZIP: TiN: NPI: Phone: Fax: TiN: Phone: Fax: TiN: NPI: NPI: NPI: Phone: Fax: TiN: NPI: NPI: NPI: NPI: DISPONDED INFORMATION Please indicate primary (CD Code: Get and specify siny other where applicable. Primary (CD Code: Secondary (CD Code: Get and specify siny other where applicable. Polase used to Lupron Depot dose is being requested: 3.75 mg 11.25 mg 22.5 mg 30 mg 45 mg Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only: Malignant sex cord-stromal tumors, prostate cancer, ocontraindication to a preferred product. Malignant sex cord-stromal tumors, prostate cancer, ocontraindication to a preferred product. Malignant sex cord-stromal tumors a prostat	Group #:					_ Carrier Name: _			
Last Name: Last Name: Check One): M.D. D.O. N.P. P.A. Address: City: State: ZIP:	Insured:								
Last Name:			de ID #:	Med	dicaid: Yes	☐ No If yes, pro	vide ID #:		
Address:	C. PRESCRIBER INFO	ORMATION							
Phone:	First Name:			Last Name:	<u>, </u>	(Check C			
Provider Email:	Address:				<u> </u>		State:	ZIP:	
Specialty (Check one): Endocrinologist Gynecologist Oncologist Other:	Phone:	Fax:		St Lic #:	NPI #:	DEA #:		UPIN:	
Dispensing Provider/Pharmacy: Patient Selected choice Self-administration: Dispensing Provider/Pharmacy: Patient Selected choice Self-administration: Physician's Office Physician's O	Provider Email:			Office Contact Name:			Phone:		
Place of Administration: Self-administration	Specialty (Check one):	: 🗌 Endocrinolo	gist 🗌 Gyned	cologist 🔲 Oncologis	st 🗌 Other:			_	
Self-administered Physician's Office Physician's Office Physician's Office Physician's Office Physician's Office Specialty Pharmacy Other Center Name:	D. DISPENSING PRO	VIDER/ADMINIS	TRATION INFO	RMATION					
Outpatient Infusion Center	Place of Administration	on:			Dispensing F	Provider/Pharmac	y: Patient Sel	ected choice	
Outpatient Infusion Center	☐ Self-administered	☐ Physic	an's Office		☐ Physician	's Office	Retail Phari	macy	
Home Infusion Center			one:		☐ Specialty			-	
Address: Address: Address: Address: Bronne: Fax: Address: Address: Address: City: State: ZIP: Phone: Fax: TIN: PlN: PlN: PlN: PlN: PRODUCT INFORMATION Request is for: Lupron Depot (leuprolide acetate for depot suspension) Dose: Frequency: DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable. Primary ICD Code: Secondary ICD Code: Other ICD Code: CINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests. For Initiation Requests (clinical documentation required for all requests): Please use the 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					Name:				
Administration code(s) (CPT):									
Address:	0 ,				-			7IP·	
City:	·				=				
Phone:	City:		State:	ZIP:					
PRODUCT INFORMATION	Phone:		Fax:						
E. PRODUCT INFORMATION Request is for: Lupron Depot (leuprolide acetate for depot suspension) Dose:			PIN:		- ''' ''		-		
Request is for: Lupron Depot (leuprolide acetate for depot suspension) Dose:					-				
F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable. Primary ICD Code: Other ICD Code:									
Primary ICD Code: Other ICD Code:						·	requency:		
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 Will 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.		RMATION - Pleas	e indicate prima						
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 Will 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 Stage Stage Stage Stage No Stage Stage Stage No Stage	Primary ICD Code:			•					
Yes No Is this request for Lupron Depot-PED?					d in its <u>entirety</u> fo	or all precertification	n requests.		
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:	For Initiation Requests (clinical documentation required for all requests):								
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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?									
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 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?									
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· · · · · · · · · · · · · · · · · ·	•	•			•	erred product.			
		•		•	•	ated for the patient'	s diagnosis?		
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Patient First Name	Patient Last Name	Patient Phone	Patient DOB				
G. CLINICAL INFORMATION (continued) – R	equired clinical information must be comple	eted in its <u>entirety</u> for all precertific	cation requests.				
Recurrent salivary gland tumors							
☐ Yes ☐ No Is the tumor androgen rece	•						
For breast cancer, endometriosis, ovarian cancer, preservation of ovarian function, recurrent menstrual related attacks in acute porphyria or uterine							
<u>leiomyomata (fibroids) indication only:</u> 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 document							
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		sion 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 II ☐ 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?							
☐ Yes ☐ No Has the patient experience	d an unacceptable toxicity or disease progr	ession while receiving the reques	ted drug?				

Continued on next page



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Page 3 of 3

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB						
G. CLINICAL INFORMATION (continued) - R	equired clinical information must be comple	l eted in its entiretv for a	Il 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 recep									
☐ Yes ☐ No Has the patient experience		•							
☐ Yes ☐ No Has the patient experienced	d an unacceptable toxicity while receiving t	he requested drug?							
☐ Endometriosis									
Yes No Has the patient received pro		on or Lupaneta Pack?							
	patient had a recurrence of symptoms?								
	tient's bone mineral density within normal li								
,	received previous therapy with the request	ed drug and Lupaneta	Pack? months						
Ovarian cancer_	_	_							
Please select: Epithelial ovarian cancer			ignant sex cord-stromal tumor						
Yes No Has the patient experienced		-							
Yes No Has the patient experienced	d an unacceptable toxicity while receiving t	he requested drug?							
☐ Preservation of ovarian function									
Yes No Is the patient premenopaus									
☐ Prevention of recurrent menstrual related									
Yes No Is the requested medication									
•	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?								
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	patient have a diagnosis of anemia (for exalog/dL)?	ample, Hct less than or	equal to 30% and/or Hgb less than or						
How long has the patient re	eceived previous therapy with the requeste	d drug and Lupaneta P	ack? 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	or to surgery for uterine	e fibroids?						
H. ACKNOWLEDGEMENT									
Request Completed By (Signature Require	ed):		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.