

Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Lupron Depot-Lupaneta (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.

When conditions are met, we will authorize the coverage of Lupron Depot-Lupaneta (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Lupron Depot (leuprolide)

Lupron Depot-Ped (leuprolide)

Lupaneta (leuprolide and norethindrone)

Other, Please specify _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

[If yes, skip to question 26.]

2. Is this a request for Lupron Depot-PED to treat central precocious puberty (CPP)? Y N

[If yes, skip to question 20.]

3. Is the patient at least 18 years old? Y N

[If no, then no further questions.]

4. Is this a request for Lupron Depot to treat advanced prostate cancer? Y N

[If no, skip to question 6.]

5. Is Lupron Depot being prescribed by or in consultation with an oncologist or urologist? Y N

[No further questions.]

6. Is this a request for Lupron Depot (3.75mg) to treat advanced breast cancer? Y N

[If yes, skip to question 10.]

7. Is this a request for Lupron Depot (3.75mg or 11.25mg) to treat advanced ovarian cancer? Y N

[If no, skip to question 11.]

8. Has the patient had inadequate response to or could not tolerate cytotoxic agents? Y N

[If yes, then skip to question 10.]

9. Is Lupron Depot being used for post-operative management? Y N

[If no, then no further questions.]

10. Is Lupron Depot being prescribed by or in consultation with an oncologist? Y N

[No further questions.]

11. Is Lupron Depot or Lupaneta being prescribed by or in consultation with a gynecologist or obstetrician? Y N

[If no, then no further questions.]

12. Is this a request for Lupaneta to treat endometriosis? Y N

[If no, skip to question 15.]

13. Has the patient had a trial and failure of at least one formulary hormonal cycle control agent (such as ethinyl estradiol plus levonorgestrel, ethinyl estradiol plus drospirenone, or ethinyl estradiol plus norgestimate), medroxyprogesterone, or Danazol? Y N

Please indicate which medications patient failed: _____

[If no, then no further questions.]

14. Has the patient already received 6 months of treatment with this medication? Y N

[If yes, skip to question 28.]

[If no, then no further questions.]

15. Is this a request for Lupron-Depot to treat endometriosis? Y N

[If no, skip to question 18.]

16. Has the patient had a trial and failure of at least one formulary hormonal cycle control agent (such as ethinyl estradiol plus levonorgestrel, ethinyl estradiol plus drospirenone, or ethinyl estradiol plus norgestimate), medroxyprogesterone, or Danazol? Y N

Please indicate which medications patient _____

[If no, then no further questions.]

17. Has the patient already received 6 months of treatment this medication? Y N

[If yes, skip to question 30.]

[If no, then no further questions.]

18. Is this request for Lupron Depot for uterine fibroids to either improve anemia or reduce uterine size before planned surgical intervention within the next 3-6 months? Y N

If yes, please document planned surgery date: _____

[If no, no further questions.]

19. Has the patient already received 6 months of treatment with Lupron Depot? Y N

[No further questions.]

20. Is therapy prescribed by or in consultation with an endocrinologist? Y N

[If no, then no further questions.]

21. Has an MRI or CT scan been performed to rule out lesions? Y N
 [If no, then no further questions.]
22. Did the patient have onset of secondary sexual characteristics earlier than 8 years of age for a female patient or 9 years of age for a male patient? Y N
 [If no, then no further questions.]
23. Has the diagnosis been confirmed by a response to a GnRH stimulation test, or if not available, other labs to support the diagnosis of CPP (ie, luteinizing hormone levels, estradiol and testosterone level)? Y N
 If yes, document test results and date drawn: _____
 [If no, then no further questions.]
24. Is the patient's bone age advanced at least 1 year beyond the chronological age? Y N
 If yes, document date of test, chronological age at the time of test, and bone age:

 [If no, then no further questions.]
25. Has a baseline height, weight and LH levels been provided? Y N
 Please document date, height, weight and LH levels: _____
 [No further questions.]
26. Is the request for Lupron Depot-PED for the treatment of central precocious puberty (CPP)? Y N
 [If yes, skip to question 37.]
27. Is this a request for Lupaneta to treat endometriosis? Y N
 [If no, skip to question 29.]
28. Does the patient have bone density values (DEXA or BMD) within normal limits? Y N
 Please provide date of Bone Density exam and result:

[If yes, skip to question 32.]

[If no, no further questions.]

29. Is this a request for Lupron-Depot to treat endometriosis? Y N

[If no, skip to question 33.]

30. Does the patient have bone density values (DEXA or BMD) within normal limits? Y N

Please provide date of Bone Density exam and result:

[If no, no further questions.]

31. Will Lupron Depot be used in combination with norethindrone acetate 5 mg daily? Y N

[If no, then no further questions.]

32. Has the patient received this medication for less than 12 months? Y N

[No further questions]

33. Does the patient have uterine fibroids? Y N

[If no, skip to question 35.]

34. Is surgical intervention scheduled? Y N

[No further questions.]

Please document date of planned surgery:

35. Does the patient have a diagnosis of advanced prostate, breast or ovarian cancer? Y N

[If no, then no further questions]

36. Has the patient received Lupron Depot for less than 2 years? Y N

[No further questions]

37. Is the patient demonstrating a clinical response to treatment as demonstrated by any of the following? A) Pubertal slowing or decline, B) Suppression of FSH, LH, estradiol/testosterone levels, or C) Normalization of bone age/height velocity Y N

Please document all that apply:

[If no, no further questions.]

38. Does the patient meet one of the following? A) Female patient who is less than 11 years of age, or B) Male patient who is less than 12 years of age Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature

Date