HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

GONADOTROPIN RELEASE HORMONE AGONISTS AND ANTAGONISTS

Eligard®, Firmagon®, Lupaneta Pack™, Lupron Depot®, Lupron Depot- Ped®, MixJect®, Orilissa®, Supprelin® LA, Synarel®, Trelstar®, Triptodur®, Vantas®, Zoladex®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Eligard® (leuprolide acetate), ☐ Firmagon® (degarelix), ☐ Lupaneta Pack™ (leuprolide acetate + norethindrone), ☐ Lupron Depot® (leuprolide acetate), ☐ Lupron Depot- Ped® (leuprolide acetate), ☐ MixJect® (triptorelin), ☐ Orilissa® (elagolix), ☐ Supprelin® LA (histrelin), ☐ Synarel® (histrelin), ☐ Trelstar® (triptorelin), ☐ Triptodur® (triptorelin), ☐ Vantas® (histrelin), ☐ Zoladex® (goserelin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
ADVANCED BREAST CANCER			
1. Is the request for the diagnosis of advanced breast cancer?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or old?	☐	☐	
3. Is the prescriber an oncologist or endocrinologist?	☐	☐	
4. Does documentation show a menstrual period in the last 12 months **OR** estradiol level >20 pg/mL?	☐	☐	**Please provide documentation**
5. Is the request for the preferred product Zoladex®?	☐	☐	
CENTRAL PRECOCIOUS PUBERTY			
1. Is the member between the ages of 2 and 9?	☐	☐	
2. Is the prescriber a pediatric endocrinologist or in consultation with one?	☐	☐	
3. Does documentation show baseline LH levels?	☐	☐	**Please provide documentation**
4. If female, does documentation show a baseline LH/FSH ratio?	☐	☐	**Please provide documentation**
5. Does documentation show the member's baseline height?	☐	☐	**Please provide documentation**

6. Does documentation show the member's baseline bone age is 1 year greater than chronological age?	☐	☐	**Please provide documentation**
7. Does documentation show the member's Tanner Stage is at least 2?	☐	☐	**Please provide documentation**
8. Have underlying diagnoses been evaluated and tested for? • Adrenal steroid levels for congenital adrenal hyperplasia • Beta human chorionic gonadotropin level for chorionic gonadotropin secreting tumor • Pelvic/adrenal/testicular ultrasound for steroid secreting tumor • CT scan of head to rule out intracranial tumor	☐	☐	**Please provide documentation**
9. Is the request for the preferred product Lupron Depot-Ped®?	☐	☐	
ENDOMETRIOSIS			
1. Is the member 18 years of age or older?	☐	☐	
2. Has the member been diagnosed with endometriosis with inadequate pain control? **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
3. Is the requesting provider an OB/GYN or in consultation with one?	☐	☐	
4. Does documentation show a negative pregnancy test?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two of the following: • A combination (estrogen-progesterone) contraceptive taken continuously, • A progestin such as DepoProvera® (medroxyprogesterone), Nexplanon® (etonogestrel) or Mirena® (levonorgestrel) • danazol	☐	☐	**Please provide documentation**
6. Is the request for the preferred product Lupron Depot®?	☐	☐	
ENDOMETRIAL THINNING			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an OB/GYN?	☐	☐	
3. Is the requested therapy for dysfunctional uterine bleeding prior to endometrial ablation?	☐	☐	**Please provide documentation**
4. Is the requested for the preferred product Zoladex®?	☐	☐	
ADVANCED PROSTATE CANCER			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting prescriber an oncologist or endocrinologist?	☐	☐	
3. Is the requested therapy for palliative treatment of advanced carcinoma of the prostate?	☐	☐	**Please provide documentation**
4. Is the request for the preferred product Lupron Depot®?	☐	☐	
STAGE B2-C PROSTATE CANCER			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an oncologist or endocrinologist?	☐	☐	
3. Is the prostate cancer stage T2b to T4 (stage B2 to C)?	☐	☐	**Please provide documentation**
4. Will the requested therapy be used in combination with an antiandrogen (e.g., flutamide, bicalutamide, nilutamide)?	☐	☐	**Please provide documentation**

5. Does documentation show that therapy initiation will be 8 weeks prior to radiotherapy or concurrent with radiotherapy?	☐	☐	**Please provide documentation**
6. Is the request for the preferred product Zoladex®?	☐	☐	
UTERINE LEIOMYOMATA			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a diagnosis of uterine leiomyomata requiring option of surgical intervention?	☐	☐	**Please provide documentation**
3. Does updated documentation demonstrate anemia?	☐	☐	**Please provide documentation**
4. Will the requested therapy be used in combination with continuous iron supplementation?	☐	☐	**Please provide documentation**
5. Does documentation show a clinical estimation of the size of uterus or fibroids?	☐	☐	**Please provide documentation**
6. Is the request for the preferred product Lupron Depot®?	☐	☐	
ADOLESCENT GENDER IDENTITY DISORDER			
1. Is the member <18 years of age?	☐	☐	
2. Is the member's Tanner Score ≥2?	☐	☐	**Please provide documentation**
3. Has the member given informed consent and the parents/legal guardians have provided signed consent to treatment and are involved in the treatment process?	☐	☐	**Please provide documentation**
4. Has the member been evaluated by a mental health specialist or a provider that is specialized in this treatment area?	☐	☐	**Please provide documentation**
5. Is the request for the preferred product Eligard®? **Lupron Depot Ped® required for at least a 3-month trial and failure of the preferred product.**	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet initial authorization criteria?	☐	☐	**Please provide documentation**
3. Does updated documentation show sustained clinical improvement from baseline?	☐	☐	**Please provide documentation**
CENTRAL PRECOCIOUS PUBERTY			
1. Does documentation show suppression of increasing LH and FSH levels from baseline?	☐	☐	**Please provide documentation**
2. Has the member's height velocity slowed or stabilized from baseline?	☐	☐	**Please provide documentation**
3. Has the member's bone age slowed from baseline?	☐	☐	**Please provide documentation**
4. Is there a stabilization or regression of the member's Tanner Staging?	☐	☐	**Please provide documentation**
5. Is the member ≤12 years of age if female or ≤13 years of age if male?			
ENDOMETRIOSIS			
1. Does the member have a recurrence of symptoms?	☐	☐	**Please provide documentation**
ADVANCED PROSTATE CANCER			
1. Is there documentation of blood LH, FSH, and serum testosterone levels documented 4 weeks after initiation of therapy?	☐	☐	**Please provide documentation**

ADOLESCENT GENDER IDENTITY DISORDER			
1. Is the member <18 years of age?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy PHARM-026
Origination Date: 07/31/2018
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/2021
Current Effective Date: 03/26/2020