

PITUITARY SUPPRESSIVE AGENTS, LHRH PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Pituitary Suppressive Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Pituitary Suppressive Agents, LHRH** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA# _____)	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Non-preferred medication requested	<input type="checkbox"/> Eligard <input type="checkbox"/> Lupaneta Pack <input type="checkbox"/> Lupron Depot-Ped Kit 3-month (11.25 mg & 30 mg)	<input type="checkbox"/> Supprelin LA <input type="checkbox"/> Trelstar syringe <input type="checkbox"/> Trelstar Depot vial	<input type="checkbox"/> Trelstar LA vial <input type="checkbox"/> Vantas Kit <input type="checkbox"/> Zoladex implant
Directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

Complete Section A AND the section applicable to the Recipient's diagnosis.

Section A: All requests

1. Is the Recipient being treated for one of the following diagnoses? *Check all that apply.*
- | | | |
|---|---|---|
| <input type="checkbox"/> advanced prostate cancer | <input type="checkbox"/> endometriosis | <input type="checkbox"/> Yes – <u>submit documentation of diagnosis</u>
<input type="checkbox"/> No – <u>submit medical literature supporting the use of the requested agent for the Recipient's diagnosis</u> |
| <input type="checkbox"/> central precocious puberty | <input type="checkbox"/> uterine fibroids | |

Section B: Advanced prostate cancer diagnosis

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class that are indicated for the treatment of advanced prostate cancer? *Check all that apply.*
- | | | |
|--|---|---|
| <input type="checkbox"/> leuprolide acetate SQ injection kit | <input type="checkbox"/> Lupron Depot Kit | <input type="checkbox"/> Yes – <u>submit documentation of medication regimen and associated trial and failure, contraindication, or intolerances</u>
<input type="checkbox"/> No |
|--|---|---|

Section C: Central precocious puberty (CPP) diagnosis

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class that are indicated for the treatment of central precocious puberty (CPP)? *Check all that apply.*
- | | | |
|--|--|---|
| <input type="checkbox"/> leuprolide acetate SQ injection kit | <input type="checkbox"/> Lupron Depot-Ped Kit 1-month (7.5 mg, 11.25 mg, or 15 mg) | <input type="checkbox"/> Yes – <u>submit documentation of medication regimen and associated trial and failure, contraindication, or intolerances</u>
<input type="checkbox"/> No |
| <input type="checkbox"/> Lupron Depot kit | <input type="checkbox"/> Synarel nasal | |

Section D: Endometriosis diagnosis

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class that are indicated for the treatment of endometriosis? *Check all that apply.*
- | | | |
|---|--|---|
| <input type="checkbox"/> Lupron Depot Kit | <input type="checkbox"/> Synarel nasal | <input type="checkbox"/> Yes – <u>submit documentation of medication regimen and associated trial and failure, contraindication, or intolerances</u>
<input type="checkbox"/> No |
|---|--|---|

Section E: Uterine fibroids diagnosis

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred agent in this class that is indicated for the treatment of uterine fibroids, Lupron Depot Kit?
- | | |
|--|---|
| | <input type="checkbox"/> Yes – <u>submit documentation of medication regimen and associated trial and failure, contraindication, or intolerances</u>
<input type="checkbox"/> No |
|--|---|

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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