PRIOR AUTHORIZATION REQUEST
Lupron

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Abnormal uterine bleeding
   - ☐ Prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment, or prior to bone marrow/stem cell transplantation (BMT/SCT)
   - ☐ Preserve ovarian function/fertility in patients undergoing chemotherapy
   - ☐ Breast cancer
   - ☐ Ovarian cancer
   - ☐ Uterine leiomyomata (fibroids)
   - ☐ Endometriosis
   - ☐ Prostate cancer
   - ☐ Gender dysphoric/gender-incongruent persons; persons undergoing gender reassignment (female-to-male [FTM] or male-to-female [MTF])
   - ☐ Head and neck cancer - salivary gland tumors
   - ☐ Polycystic ovarian syndrome (PCOS)
   - ☐ Hirsutism
   - ☐ Premenstrual syndrome (PMS)
   - ☐ Menstrual migraine
   - ☐ All other indications or diagnoses – Please specify _____
2. ☐ Yes ☐ No Has the patient previously used a gonadotropin-releasing hormone [GnRH] agonist (for example, Lupron-Depot) or antagonist (for example, Orilissa)?
3. ☐ Yes ☐ No Has the patient tried one of the following: a contraceptive (for example, combination oral contraceptives, levonorgestrel-releasing intrauterine systems?
4. ☐ Yes ☐ No Does the patient have a contraindication to one of the following: a contraceptive (for example, combination oral contraceptives, levonorgestrel-releasing intrauterine systems?

If you have any questions, call: 800-753-2851

PRIOR AUTHORIZATION REQUEST

Lupron

5. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients?
6. ☐ Yes ☐ No Does the patient have recurrent disease with distant metastases?
7. ☐ Yes ☐ No Does the patient have androgen receptor (AR)-positive disease?
8. ☐ Yes ☐ No Is the medication being prescribed by or in consultation with an oncologist?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 800-753-2851