maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

GnRH Analogs

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this request for initial therapy or continuation of therapy with the requested medication?
[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 18)

2 What is the diagnosis or indication?
[] Endometriosis (If checked, go to 3)

[] Uterine Leiomyoma (fibroids) (If checked, go to 6)

[] Central Precocious Puberty (CPP) (If checked, go to 9)

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	[] Other (If checked, no further questions)		
3	Is this medication being prescribed by or consultation with a gynecologist or obstetrician? [If no, no further questions.]	Yes	No
4	Is the patient 18 years of age OR older? [If no, no further questions.]	Yes	No
5	Has the patient tried and failed AT LEAST one formulary hormonal cycle control agent (such as, Portia, Ocella, Previfem), medroxyprogesterone, or Danazol? [No further questions.]	Yes	No
6	Is this medication being prescribed by or consultation with gynecologist or obstetrician? [If no, no further questions.]	Yes	No
7	Is the patient 18 years of age OR older? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed to improve anemia and/or reduce uterine size for 3-6 months prior to planned surgical intervention? [No further questions.]	Yes	No
9	Is this medication being prescribed by or consultation with an endocrinologist? [If no, no further questions.]	Yes	No
10	Has the patient undergone a MRI or CT scan to rule out lesions? [If no, no further questions.]	Yes	No
11	Is the patient a female or a male? [] Female (a female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression) (If checked, go to 13) [] Male (a male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) (If checked, go to 12)		
12	Has the patient had the onset of secondary sexual characteristics prior to 9 years of age? [If yes, skip to question 14.] [If no, no further questions.]	Yes	No
13	Has the patient had the onset of secondary sexual characteristics prior to 8 years of age? [If no, no further questions.]	Yes	No

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14	Has there been a response to a GnRH stimulation test? [If yes, skip to question 16.]	Yes	No
15	Have other labs been done to support CPP such as luteinizing hormone levels, estradiol and testosterone level? [If no, no further questions.]	Yes	No
16	Has the patient's bone age advanced 1 year beyond the chronological age? [If no, no further questions.]	Yes	No
17	Has information on patient's height, weight and LH levels at baseline been provided? If yes, please provide patient's height, weight and LH levels at baseline: _____ [No further questions.]	Yes	No
18	What is the diagnosis or indication? [] Endometriosis (If checked, no further questions) [] Uterine Leiomyoma (fibroids) (If checked, no further questions) [] Central Precocious Puberty (CPP) (If checked, go to 19) [] Other (If checked, no further questions)		
19	Has the patient had a clinical response to treatment (such as, pubertal slowing or decline, height velocity, bone age, LH, or estradiol and testosterone level)? [If no, no further questions.]	Yes	No
20	Is the patient a female or a male? [] Female (a female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression) (If checked, go to 21) [] Male (a male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) (If checked, go to 22)		
21	Is the patient LESS THAN 11 years of age? [No further questions.]	Yes	No
22	Is the patient LESS than 12 years of age?	Yes	No

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

If you have any questions, call: 1-888-258-8250

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

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