Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Leuprolide (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 New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Leuprolide (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

leuprolide acetate for injection

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

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

   [If no, skip to question 15.]

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

   [If no, skip to question 4.]

3. Has the member received Leuprolide for less than 2 years? Y N

   [No further questions]

4. Does the member have a diagnosis of gender dysphoria/gender incongruence? Y N

   [If no, skip to question 6.]

5. Has the member had a response to treatment? Y N

   Note: Lab results to support response to treatment (i.e., FSH, LH, weight, height, Tanner stage (if applicable), bone age (if applicable)) are required.

   [No further questions.]

6. Is the request for the treatment of uterine leiomyoma (fibroids)? Y N

   [If yes, then no further questions.]

7. Is the request for treatment of a member with dysfunctional uterine bleeding? Y N

   [If yes, then no further questions.]

8. Does the member have a diagnosis of central precocious puberty? Y N

   [If no, skip to question 11.]

9. Is the request for a female member who is less than 11 years of age or a male member who is less than 12 years of age? Y N

   [If no, then no further questions.]

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

    Please document all that apply: _____

    [No further questions.]

11. Does the member have a diagnosis of endometriosis? Y N

    [If no, then no further questions.]

12. Has the member received less than or equal to 6 months of therapy? Y N

    [If no, then no further questions.]

13. Will the patient have a bone density assessment prior to retreatment? Y N

    [If no, then no further questions.]

14. Will leuprolide be given with norethindrone acetate 5 mg by mouth daily? Y N

    [No further questions.]

15. Does the member have a diagnosis of advanced prostate cancer? Y N

    [If no, skip to question 19.]

16. Is the member at least 18 years old? Y N

    [If no, then no further questions.]

17. Is the requested drug being prescribed by or in consultation with an oncologist or urologist? Y N

    [If no, then no further questions.]

18. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [No further questions.]

19. Is therapy being requested for treatment of a member with gender dysphoria/gender incongruence? Y N

    [If no, skip to question 32.]

20. Is the diagnosis of gender dysphoria supported by the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria and an International Classification of Diseases (ICD) code? Y N

    [If no, then no further questions.]

21. Is the request for a member 18 years of age or older? Y N

    [If yes, skip to question 28.]

22. Is therapy being prescribed by a pediatric endocrinologist that has collaborated care with a mental health provider (MHP)? Y N

    [If no, then no further questions.]

23. Is the request for a member who exhibits signs of puberty and has reached at least Tanner stage 2? Y N

    [If no, then no further questions.]

24. Has the member made a fully informed decision and given consent? Y N

    [If no, then no further questions.]

25. Has the member's parent/guardian given consent to treatment? Y N

    [If no, then no further questions.]

26. Are the member's comorbid conditions reasonably controlled? Y N

    [Note: If there are no comorbid conditions, please answer Yes.]

    [If no, then no further questions.]

27. Has the member been educated on any contraindications and side effects to therapy? Y N

    [If yes, skip to question 31.] [If no, then no further questions.]

28. Is therapy being prescribed by an endocrinologist that has collaborated care with a mental health provider (MHP)? Y N

    [If no, then no further questions.]

29. Is the request for a member who has the capacity to make a fully informed decision and is consenting to treatment? Y N

    [If no, then no further questions.]

30. Are mental health concerns, if present, reasonably well controlled? Y N

    [Note: If there are no mental health concerns, please answer Yes.]

    [If no, then no further questions.]

31. Has the member been informed of fertility preservation options prior to treatment? Y N

    [No further questions.]

32. Is therapy being requested for treatment of a member with endometriosis? Y N

    [If no, skip to question 37.]

33. Has the member had a trial and failure of at least one formulary hormonal cycle control agent (for example, Portia (ethinyl estradiol plus levonorgestrel), Ocella (ethinyl estradiol plus drospirenone), or Previfem (ethinyl estradiol plus norgestimate)), medroxyprogesterone, or Danazol? Y N

    Please indicate which medication(s) the member tried:

    _____

    [If no, then no further questions.]

34. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [If no, then no further questions.]

35. Is the member at least 18 years old? Y N

    [If no, then no further questions.]

36. Is Leuprolide being prescribed by or in consultation with a gynecologist or obstetrician? Y N

    [No further questions.]

37. Is the request for uterine leiomyoma (fibroids) to either improve anemia and/or reduce uterine size before planned surgical intervention? Y N

    If yes, please document planned surgery date: _____

    [If no, skip to question 42.]

38. Is the member at least 18 years old? Y N

    [If no, then no further questions.]

39. Is Leuprolide being prescribed by or in consultation with a gynecologist or obstetrician? Y N

    [If no, then no further questions.]

40. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [If no, then no further questions.]

41. Has the member had a trial and failure of iron to correct anemia? Y N

    [No further questions.]

42. Is Leuprolide being requested for use as an endometrial thinning agent for dysfunctional uterine bleeding? Y N

    [If no, skip to question 47.]

43. Is Leuprolide being prescribed by or in consultation with a gynecologist or obstetrician? Y N

    [If no, then no further questions.]

44. Is the member at least 18 years old? Y N

[If no, then no further questions.]

45. Does the member have planned endometrial ablation or hysterectomy within the next 4-8 weeks? Y N

    If yes, please document date surgery is scheduled:_____

    [If no, then no further questions.]

46. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [No further questions.]

47. Does the member have a diagnosis of central precocious puberty? Y N

    [If no, skip to question 56.]

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

    [If no, then no further questions.]

49. Has an MRI or CT scan been performed to rule out brain lesions or tumors? Y N

    [If no, then no further questions.]

50. Did the member have onset of secondary sexual characteristics earlier than 8 years of age for a female member and 9 years of age for a male member? Y N

    [If no, then no further questions.]

51. 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 such as luteinizing hormone levels, estradiol and testosterone level? Y N

    If yes and confirmed by a GnRH stimulation test, document test results, date drawn, and attach reference labs for comparison.

    _____

    If yes and confirmed by other labs, document test results and date drawn:

    _____

    [If no, then no further questions.]

52. Is the member'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.]

53. Have a baseline height and weight been provided? Y N

    Please document date, height and weight:_____

    [If no, then no further questions.]

54. Is the request for a female member who is less than 11 years of age or a male member who is less than 12 years of age? Y N

    [If no, then no further questions.]

55. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [No further questions.]

56. Does the member have a diagnosis of advanced breast cancer? Y N

    [If no, skip to question 60.]

57. Is therapy being prescribed by or in consultation with an oncologist? Y N

    [If no, then no further questions.]

58. Is the member at least 18 years of age? Y N

    [If no, then no further questions.]

59. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? Y N

    [No further questions.]

60. Does the member have a diagnosis of advanced ovarian cancer? Y N

    [If no, then no further questions.]

61. Is therapy being prescribed by or in consultation with an oncologist? Y N

    [If no, then no further questions.]

62. Is the member at least 18 years of age? Y N

    [If no, then no further questions.]

63. Is the request for a member who had an inadequate response to or cannot tolerate cytotoxic agents? Y N

[If yes, skip to question 65.]

64. Is the requested drug being used for post-operative management? Y N

[If no, then no further questions.]

65. Has the member had a trial of one preferred Gonadotropin Releasing Hormone (GnRH) Analog? 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**