Lupron Depot-PED® (leuprolide acetate for depot suspension) Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:	*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Endocrinologist** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Lupron Depot-PED Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ **Central precocious puberty (CPP)**
Please indicate the patient's sex: ☐ Male ☐ Female
☐ Yes ☐ No Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging, such as computed tomography (CT scan), magnetic resonance imaging (MRI), or ultrasound?
☐ Yes ☐ No Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a GnRH (gonadotropin-releasing hormone) agonist test or a pubertal level of a third generation LH (luteinizing hormone) assay?
☐ Yes ☐ No Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty?

☐ **Gender dysphoria**
☐ Yes ☐ No Is Lupron Depot-PED prescribed for an adolescent patient for pubertal hormonal suppression in preparation for gender reassignment?
→ ☐ Yes ☐ No Is the patient undergoing gender reassignment?
→ ☐ Yes ☐ No Will the patient receive Lupron Depot-PED concomitantly with cross sex hormones?
→ Indicate the Tanner Stage of puberty the patient has reached: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

For Continuation Requests (clinical documentation required for all requests):

☐ **Central precocious puberty (CPP)**
Please indicate the patient's sex: ☐ Male ☐ Female

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested drug being prescribed for an adolescent patient for pubertal hormonal suppression in preparation for gender reassignment?
→ ☐ Yes ☐ No Is the patient undergoing gender reassignment?
→ ☐ Yes ☐ No Will the patient receive the Lupron Depot-PED concomitantly with cross sex hormones?
→ Indicate the Tanner Stage of puberty the patient has reached: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.