Lupron Depot® (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** ☐ **Gynecologist** ☐ **Oncologist** ☐ **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 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):
☐ **Yes** ☐ **No** **Is this request for Lupron Depot-PED?**
→ **Please use the Lupron Depot-PED form for this request.**

For gender dysphoria, malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors indications only:
Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **7.5 mg** ☐ **11.25 mg** ☐ **22.5 mg** ☐ **30 mg** ☐ **45 mg**
☐ **Gender dysphoria**
☐ Yes ☐ No Is Lupron Depot being prescribed for pubertal hormonal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive Lupron Depot concomitantly with gender-affirming hormones?
→ Indicate the Tanner Stage of puberty the patient has reached: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown
☐ **Malignant sex cord-stromal tumors**
☐ **Prostate cancer**
☐ **Recurrent salivary gland tumors**
☐ Yes ☐ No Is the tumor androgen receptor positive?

For breast cancer, endometriosis, ovarian cancer, preservation of ovarian function, recurrent menstrual related attacks in acute porphyria or uterine fibroids indication only:
Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **11.25 mg**
☐ **Breast cancer**
Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown
☐ **Endometriosis**
☐ **Ovarian cancer**
Please select: ☐ Epithelial ovarian cancer ☐ Fallopian tube cancer ☐ Primary peritoneal cancer ☐ Malignant sex cord-stromal tumor

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Preservation of ovarian function**
- ☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
- ☐ Yes ☐ No Is Lupron Depot being requested to prevent recurrent menstrual related attacks in acute porphyria?
- ☐ Yes ☐ No Is Lupron Depot prescribed by, or in consultation with, a physician experienced in the management of porphyrias?

☐ **Uterine fibroids**
- ☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10 g/dL)?
  - → ☐ Yes ☐ No Will Lupron Depot be used prior to surgery for uterine fibroids?

For Continuation Requests (clinical documentation required for all requests):
For gender dysphoria, malignant sex cord-stromal tumors, prostate cancer, recurrent salivary gland tumors continuation requests only:

Please select which Lupron Depot dose is being requested: ☐ **3.75 mg** ☐ **7.5 mg** ☐ **11.25 mg** ☐ **22.5 mg** ☐ **30 mg** ☐ **45 mg**

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

☐ **Malignant sex cord-stromal tumors**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Prostate cancer**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Recurrent salivary gland tumors**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

For breast cancer, endometriosis, ovarian cancer, preservation of ovarian function, recurrent menstrual related attacks in acute porphyria or uterine fibroids continuation requests only:

Please select Lupron Depot dose for the following indications: ☐ **3.75 mg** ☐ **11.25 mg**

☐ **Breast cancer**
- Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Endometriosis**
- ☐ Yes ☐ No Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
  - → ☐ Yes ☐ No Has the patient had a recurrence of symptoms?
  - ☐ Yes ☐ No Is the patient's bone mineral density within normal limits?
  - How long has the patient received previous therapy with Lupron Depot and Lupaneta Pack? _____ months

☐ **Ovarian cancer**
- Please select: ☐ Epithelial ovarian cancer ☐ Fallopian tube cancer ☐ Primary peritoneal cancer ☐ Malignant sex cord-stromal tumor
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Preservation of ovarian function**
- ☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
- ☐ Yes ☐ No Is Lupron Depot being requested to prevent recurrent menstrual related attacks in acute porphyria?
- ☐ Yes ☐ No Is Lupron Depot prescribed by, or in consultation with, a physician experienced in the management of porphyrias?

☐ **Uterine fibroids**
- ☐ Yes ☐ No Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
  - → ☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10g/dL)?
  - How long has the patient received previous therapy with Lupron Depot and Lupaneta Pack? _____ months
  - → ☐ Yes ☐ No Does the patient have a diagnosis of anemia (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10g/dL)?
    - → ☐ Yes ☐ No Will Lupron Depot be used prior to surgery for uterine fibroids?

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.