Trelstar® (triptorelin pamoate) 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)*: ☐ **Oncologist** ☐ **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: Trelstar (triptorelin pamoate) 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):

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

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

☐ **Prostate cancer**
- ☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Eligard?
- ☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Firmagon?

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

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

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

☐ **Prostate cancer**
- ☐ Yes ☐ No Has the patient experienced clinical benefit to therapy while receiving the requested drug (e.g., serum testosterone less than 50 ng/dl)?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

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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.