Zoladex® (goserelin acetate) 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: Zoladex (goserelin acetate) 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):

For Zoladex 3.6 mg requests only:

☐ **Breast cancer**
Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown

☐ **Chronic anovulatory uterine bleeding**
☐ Yes ☐ No Will the requested medication be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia?
☐ Yes ☐ No Please indicate how many months the patient has already received the requested medication for this indication: _____

☐ **Dysfunctional uterine bleeding**
☐ Yes ☐ No Will the requested medication be used as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding?

☐ **Endometriosis**
Please indicate how many months the patient has already received the requested medication for this indication: _____

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested medication 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 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?

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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.

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

☐ **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?

☐ **Uterine leiomyomata (fibroids)**
- ☐ Yes ☐ No Will the requested medication be given prior to surgery?

Please indicate how many months the patient has already received the requested medication for this indication: _____

For Zoladex 10.8 mg requests only:

☐ **Breast cancer**

Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown

☐ **Gender dysphoria**
- ☐ Yes ☐ No Is the requested medication 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 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

☐ **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):

☐ **Breast cancer**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while on the current regimen?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while on the current regimen?

☐ **Gender dysphoria**
- ☐ Yes ☐ No Is the requested medication 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 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?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while on the current regimen?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while on the current regimen?

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

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.