



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

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(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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	

## C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy: Patient Selected choice</b>	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____	

## E. PRODUCT INFORMATION

**Request is for: Lupron Depot (leuprolide acetate for depot suspension) 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 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**

**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?

**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 leiomyomata (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**

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.**

- Ovarian cancer**  
 Please select:  Epithelial ovarian cancer  Fallopian tube cancer  Primary peritoneal cancer  Malignant sex cord-stromal tumor
- 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 the requested drug being requested to prevent recurrent menstrual related attacks in acute porphyria?  
 Yes  No Is the requested drug being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
- Uterine leiomyomata (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 the requested drug 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 an unacceptable toxicity or disease progression while receiving the requested drug?
  - Prostate cancer**  
 Yes  No Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50ng/dl)?  
 Yes  No Has the patient experienced an unacceptable toxicity while receiving the requested drug?
  - Recurrent salivary gland tumors**  
 Yes  No Has the patient experienced an unacceptable toxicity or disease progression 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 the requested medication 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 the requested drug 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 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?
  - Uterine leiomyomata (fibroids)**  
 Yes  No Has the patient received previous therapy with the requested drug 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 the requested drug 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 the requested drug 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.