



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Eligard-Vabrinty - Exchange

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of gender dysphoria? If YES, go to 2. If NO, go to 6.

Yes checkbox

No checkbox

Q2. Is the patient less than 18 years of age? If YES, go to Q3. If NO, go to Q5.

Yes checkbox

No checkbox

Q3. Is the requested drug being prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?

Yes checkbox

No checkbox

Q4. For patients less than 18 years of age, does the patient meet all of the following?

- The member is able to make an informed decision to engage in treatment.
The member has reached Tanner stage 2 of puberty or greater.
The member's comorbid conditions are reasonably controlled.
The member has been educated on any contraindications and side effects to therapy.



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> The member has been informed of fertility preservation options.	
Q5. For patients 18 years of age and older, does the patient meet all of the following? <input type="checkbox"/> The member is able to make an informed decision to engage in treatment. <input type="checkbox"/> The member will receive the requested medication concomitantly with gender-affirming hormones. <input type="checkbox"/> The member's comorbid conditions are reasonably controlled. <input type="checkbox"/> The member has been educated on any contraindications and side effects to therapy. <input type="checkbox"/> The member has been informed of fertility preservation options.	
Q6. Is this an initial request? If YES, go to Q7. If NO, go to Q8. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Does the patient have a diagnosis of prostate cancer OR recurrent, unresectable, or metastatic salivary gland tumors when the tumor is androgen receptor positive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the request for ovarian suppression in premenopausal members with hormone receptor-positive breast cancer at higher risk for recurrence (e.g., young age, high-grade tumor, lymph-node involvement) when used in combination with endocrine therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. For continuation, what is the diagnosis? <input type="checkbox"/> Salivary gland tumors - Go to 10. <input type="checkbox"/> Prostate cancer - Go to 11. <input type="checkbox"/> Ovarian suppression in premenopausal member with hormone receptor-positive breast cancer - Go to 12.	
Q10. Is the patient experiencing clinical benefit from therapy and has not experienced an unacceptable toxicity? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q11. Is the patient experiencing clinical benefit from therapy (e.g., serum testosterone less than 50 ng/dL) and has not experienced an unacceptable toxicity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Was the member premenopausal at diagnosis and is still undergoing treatment with endocrine therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026