



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Lupron Depot-Ped

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, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, 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. Is this an initial or continuation request? If an initial request, go to 2. If continuation request, go to 11.

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of central precocious puberty (CPP)? If YES, go to 3. If NO, go to 8.

Yes checkbox

No checkbox

Q3. The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.

Yes checkbox

No checkbox

Q4. The assessment of bone age versus chronological age supports the diagnosis of CPP.

Yes checkbox

No checkbox

Q5. The member meets either of the following criteria:



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Patient Name:	Prescriber Name:
<input type="checkbox"/> The member is a female and was less than 8 years of age at the onset of secondary sexual characteristics.	
<input type="checkbox"/> The member is a male and was less than 9 years of age at the onset of secondary sexual characteristics.	
Q6. The pathologic cause of CPP has been assessed (e.g., imaging screening for intracranial tumors, genetic testing for familial CPP [e.g., MKRN3 or DLK1 mutations]).	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is the requested medication being used for gender dysphoria?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For an adolescent member for pubertal hormonal suppression: does the patient meet all of the following criteria? If YES, go to 10. If not an adolescent go to 9.	
<input type="checkbox"/> The patient has a diagnosis of gender dysphoria.	
<input type="checkbox"/> The patient is able to make an informed decision to engage in treatment.	
<input type="checkbox"/> The patient has reached Tanner stage 2 of puberty or greater.	
<input type="checkbox"/> The patient's comorbid conditions are reasonably controlled.	
<input type="checkbox"/> The patient has been educated on any contraindications and side effects to therapy.	
<input type="checkbox"/> The patient has been informed of fertility preservation options.	
Q9. Does the patient meet all of the following criteria for gender transition?	
<input type="checkbox"/> The patient has a diagnosis of gender dysphoria.	
<input type="checkbox"/> The patient is able to make an informed decision to engage in treatment.	
<input type="checkbox"/> The patient will receive the requested medication concomitantly with gender-affirming hormones.	
<input type="checkbox"/> The patient's comorbid conditions are reasonably controlled.	
<input type="checkbox"/> The patient has been educated on any contraindications and side effects to therapy.	
<input type="checkbox"/> The patient has been informed of fertility preservation options.	
Q10. Is the requested medication being prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal	



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Patient Name:	Prescriber Name:
medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider for patients less than 18 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. For continuation, what is the diagnosis? <input type="checkbox"/> CCP - go to 12 <input type="checkbox"/> Gender dysphoria, pubertal hormonal suppression in adolescent - go to 15 <input type="checkbox"/> Gender dysphoria, gender transition - go to 16	
Q12. The member is currently receiving the requested medication through a paid pharmacy or medical benefit. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. The member is either a female less than 12 years of age or a male less than 13 years of age. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement). <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient meet all of the following criteria? <input type="checkbox"/> The patient has a diagnosis of gender dysphoria. <input type="checkbox"/> The patient is able to make an informed decision to engage in treatment. <input type="checkbox"/> The patient has previously reached Tanner stage 2 of puberty or greater. <input type="checkbox"/> The patient's comorbid conditions are reasonably controlled. <input type="checkbox"/> The patient has been educated on any contraindications and side effects to therapy. <input type="checkbox"/> Before the start of therapy, the patient has been informed of fertility preservation options.	
Q16. Does the patient meet all of the following criteria?	



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Patient Name:	Prescriber Name:
<input type="checkbox"/> The patient has a diagnosis of gender dysphoria. <input type="checkbox"/> The patient is able to make an informed decision to engage in treatment. <input type="checkbox"/> The patient will receive the requested medication concomitantly with gender-affirming hormones. <input type="checkbox"/> The patient's comorbid conditions are reasonably controlled. <input type="checkbox"/> The patient has been educated on any contraindications and side effects to therapy. <input type="checkbox"/> Before the start of therapy, the patient has been informed of fertility preservation options.	
Q17. Additional Information:	

Prescriber Signature

Date

v2026