Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Gonadotropin Releasing Hormone Agonist

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 request for the treatment of gender dysphoria? (If so, please refer to the Treatment of Gender Dysphoria criteria).

☐ Yes ☐ No

Q2. Is the request for a formulary medication?

☐ Yes ☐ No

Q3. Has the patient tried and failed or has a contraindication or intolerance to formulary medications? (Please attach documentation).

☐ Yes ☐ No

Q4. What is the drug being requested for?

☐
For the Management of Endometriosis
☐ For the Preoperative Hematologic Improvement of Patients with Anemia Caused by Uterine Leiomyomata
☐ For Palliative Treatment of Advanced Prostate Cancer
☐
For the Treatment of Children with Central Precocious Puberty

Q5. Does the patient have a diagnosis of endometriosis confirmed by a workup/evaluation (versus presumptive treatment)? (Please attach documentation).

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is the medication being requested for management of endometriosis, including pain relief and reduction of endometriotic lesions?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the patient pregnant?

☐ Yes ☐ No

Q9. Is the request from, or in consultation with, a gynecologist?

☐ Yes ☐ No

Q10. If requesting Lupron Depot, is it being prescribed as combination treatment with norethindrone 5 mg once daily? (When combination treatment is not going to be prescribed, please attach documentation as to the reason why the risks of Lupron Depot in combination treatment with norethindrone outweigh the benefits).

☐ Yes ☐ No

Q11. Has the patient experienced trial and failure and/or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDS) AND at least one 3 month course of a contraceptive (either oral or non-oral) or depot medroxyprogesterone acetate?

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of uterine leiomyomata confirmed by a workup/evaluation (versus presumptive treatment)? (Please attach documentation).

☐ Yes ☐ No

Q13. Is Lupron Depot being requested for preoperative hematologic improvement of a patient with anemia caused by uterine leiomyomata? (Please attach documentation).

☐ Yes ☐ No

Q14. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q15. Is the patient pregnant?

☐ Yes ☐ No

Q16. Is the request from, or in consultation with, a gynecologist?

☐ Yes ☐ No

Q17. Does the patient have anemia that did not respond to treatment with a one month trial of iron alone?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q18. Has the patient experienced trial and failure and/or intolerance to at least one 3 month course of treatment with a contraceptive (either oral or non-oral)?	
☐ Yes	☐ No
Q19. Is Lupron Depot to be used concomitantly with iron?	
☐ Yes	☐ No
Q20. Does the patient have a histologically confirmed diagnosis of advanced prostate cancer? (Please attach documentation).	
☐ Yes	☐ No
Q21. Is the patient 18 years of age or older?	
☐ Yes	☐ No
Q22. Is the request from, or in consultation with, an oncologist or urologist?	
☐ Yes	☐ No
Q23. Will serum testosterone and PSA levels be periodically monitored throughout the course of treatment?	
☐ Yes	☐ No
Q24. Does the patient have a diagnosis of central precocious puberty? (Please attach documentation).	
☐ Yes	☐ No
Q25. Is the patient less than 11 years of age if a female or less than 12 years of age if a male?	
☐ Yes	☐ No
Q26. Did the onset of secondary sexual characteristics begin before the age of 8 if a female OR before the age of 9 if a male?	
☐ Yes	☐ No
Q27. Has the diagnosis been confirmed by a response to a GNRH stimulation test, or if not available, other labs to support the diagnosis of Central Precocious Puberty (such as luteinizing hormone levels, estradiol, testosterone level)? (Please attach documentation).	
☐ Yes	☐ No
Q28. Have baseline evaluations including height, weight, and the following been completed? (Please attach documentation). a. Diagnostic imaging of the brain to rule out intracranial tumor b. Pelvic/testicular/adrenal ultrasound to rule out steroid secreting tumors c. Human chorionic gonadotropin levels to rule out a chorionic gonadotropin secreting tumor (males only)	

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Patient Name:	**Prescriber Name:**

d. Adrenal steroid measurements to exclude congenital adrenal hyperplasia

☐ Yes ☐ No

Q29. Requested Duration:

☐ 3 Months ☐ 6 Months

Q30. Additional Information:

Prescriber Signature

Date

Updated 2018