Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Pituitary Suppressive Agents - LHRH

**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: | |
| Patient Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *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 the requested drug for an indication that is included in the United States (U.S.) Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the requested drug prescribed at a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. Is the patient age-appropriate for the requested drug according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. For diagnosis of central precocious puberty, the medication prescribed by or in consultation with a pediatric endocrinologist?

☐ Yes ☐ No

Q6. For a diagnosis of central precocious puberty, is the patient <11 years of age for females or <12 years of age for males?

☐ Yes ☐ No

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Q7. For a diagnosis of central precocious puberty, has the patient developed the onset of secondary sexual characteristics earlier than 8 years of age in females and 9 years of age in males?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of gender dysphoria?

☐ Yes ☐ No

Q9. Is the patient an adolescent?

☐ Yes ☐ No

Q10. Is the requested drug prescribed by or in consultation with a pediatric endocrinologist, adolescent medicine specialist, or medical provider with experience and/or training in transgender medicine?

☐ Yes ☐ No

Q11. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people?

☐ Yes ☐ No

Q12. Is the patient an adult?

☐ Yes ☐ No

Q13. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?

☐ Yes ☐ No

Q14. Is the requested drug prescribed in a manner consistent with current medical literature?

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of endometriosis?

☐ Yes ☐ No

Q16. Is the diagnosis of endometriosis confirmed by laparoscopy OR supported by chart documentation of an adequate work-up that includes the clinical rationale for the diagnosis?

☐ Yes ☐ No

Q17. Does the patient have a history of therapeutic failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs), AND therapeutic failure (based on a 3-month trial), contraindication, or intolerance to oral contraceptives?

☐ Yes ☐ No

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Q18. Is the requested drug prescribed by or in consultation with a gynecologist?

☐ Yes ☐ No

Q19. Is the requested drug being used for the preservation of ovarian function?

☐ Yes ☐ No

Q20. Is the patient receiving cancer treatment that is associated with premature ovarian failure (based on NCCN guidelines or peer-reviewed medical literature)?

☐ Yes ☐ No

Q21. Is the requested drug Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone)?

☐ Yes ☐ No

Q22. Is Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone) being used for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal woman?

☐ Yes ☐ No

Q23. Does the patient have a history of therapeutic failure (based on a 3-month trial), contraindication, or intolerance of contraceptives?

☐ Yes ☐ No

Q24. Does the patient have a history of depression and/or suicidal thoughts or behaviors or is currently receiving treatment for depression and/or suicidal thoughts or behavior?

☐ Yes ☐ No

Q25. Has a behavioral health assessment been performed prior to use of Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone)?

☐ Yes ☐ No

Q26. Is the requested drug a non-preferred agent?

☐ Yes ☐ No

Q27. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Pituitary Suppressive Agents, LHRH approved or medically accepted for the patient's indication?

☐ Yes ☐ No

Q28. Requested Duration:

☐ 12 Months

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Q29. Additional Information:

Prescriber Signature

Date

*Updated for 2022*