

# Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Lupron Depot (leuprolide)

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Provider Office Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

**FDA-approved indications:** Treatment of Advanced prostatic cancer, Endometriosis, Uterine leiomyomata (fibroids), and Central Precocious Puberty (CPP).

**Indicate where the patient will receive injections:**

- Ambulatory Infusion Center  
 Name of Infusion Center: \_\_\_\_\_
- Physician's office
- Other: \_\_\_\_\_

**Indicate the product/dosage requested:**

- Lupron Depot 3.75 mg (monthly)
- Lupron Depot 7.5 mg (monthly)
- Lupron Depot 3 month 11.25 mg (every 3 months)
- Lupron Depot 3 month 22.5 mg (every 3 months)
- Lupron Depot 4 month 30 mg (every 4 months)
- Lupron Depot 6 month 45 mg (every 6 months)
- Lupron Depot Ped 7.5 mg (monthly)
- Lupron Depot Ped 11.25 mg (monthly)
- Lupron Depot Ped 15 mg (monthly)

**Priority Health Precertification Requirements (one of the following diagnoses is required):**

- Prostate cancer
- Endometriosis
- Uterine leiomyomata
- Central precocious puberty

**Duration of authorization:**

If criteria is met, approval will be granted for 1 year.

**Reauthorization:**

Continuation greater than 1 year requires a bone density test. Authorizations will be entered in 1 year increments.

**For Internal Use Only**

Original Date of Req: \_\_\_\_\_ Non-Urgent: \_\_\_ Urgent: \_\_\_ Retro: \_\_\_ Method: Phone \_\_\_ Fax \_\_\_ Ltr \_\_\_ Coord. Initial \_\_\_

Approved: \_\_\_ Denied: \_\_\_ Letter Type: Denial \_\_\_ 48 hr \_\_\_ Off-Label Use \_\_\_ Verbal: Y \_\_\_ N \_\_\_ Inquiry number: \_\_\_\_\_

Product: HMO \_\_\_ PPO \_\_\_ ASO \_\_\_ POS \_\_\_ Caid \_\_\_ MICHild \_\_\_ Mcare \_\_\_ McarePlus \_\_\_ McareRX \_\_\_ McareValue \_\_\_ EGMcare \_\_\_

Formulary (11/0030/R0) \_\_\_ Non-Formulary (11/0032/R0) \_\_\_

Dte Addt Info Req \_\_\_\_\_ by: Phone \_\_\_ Fax \_\_\_ Dte 48/OL Ltr sent: \_\_\_\_\_ Dte 2nd 48/OL Ltr Sent (Caid only) \_\_\_\_\_

Date All Info Recvd \_\_\_\_\_ Date of Decision to Deny: \_\_\_\_\_ RPh Initials: \_\_\_\_\_

Notified: \_\_\_\_\_ of Denial on: \_\_\_\_\_ by: Ph \_\_\_ Fax \_\_\_