iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
LUPRON DEPOT – PEDIATRIC

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Lupron Depot - Pediatric. Payment will be considered for patients when the following is met:

1) Patient has a diagnosis of central precocious puberty (CPP); and

2) Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and

3) Patient is currently < 11 years of age for females or < 12 years of age for males; and

4) Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and

5) Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and

6) Baseline evaluations including the following have been conducted and/or evaluated:

   a) Height and weight measurements; and

   b) Sex steroid (testosterone or estradiol) levels have been obtained; and

   c) Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and

   d) Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and

   e) Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and

   f) Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and

7) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

When criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted at 6 month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

Preferred

☐ Lupron Depot-Ped (1-Month)

Non-Preferred

☐ Lupron Depot-Ped (3-Month)

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males? ☐ No ☐ Yes: provide age of onset and description:_____

Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test?
☐ No ☐ Yes (attach results)

Documentation of advanced bone age (defined as ≥ two standard deviations above the gender/age related mean)? ☐ No ☐ Yes (attach results)

Baseline evaluations:

Height:_____ Date obtained:_____

Weight:_____ Date obtained:_____

Sex steroid (testosterone/estradiol) levels obtained? ☐ No ☐ Yes (attach results)

Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor?
☐ No ☐ Yes (attach results)

Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors?
☐ No ☐ Yes (attach results)

Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor?
☐ No ☐ Yes (attach results)

Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia?
☐ No ☐ Yes (attach results)

Setting to be administered:

☐ Member's home by home health ☐ Long-term care facility ☐ Other:_____

Age override consideration:

Documentation of medical necessity for continued treatment beyond the following ages:
females ≥ 11 years of age and males ≥ 12 years of age:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*

Rev. 4/19