FAX Completed Form To
1.877.386.4695

Request for Prior Authorization
LUPRON DEPOT – ADULT

Provider Help Desk
1.866-399-0928

(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 (leuprolide acetate). Payment will be considered for patients under the following conditions:

1) Patient meets the FDA approved age; and

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

3) Patient has a diagnosis of endometriosis for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of hormonal contraceptive has failed; or

4) Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or

5) Patient has a diagnosis of advanced prostate cancer.

Therapy will be limited as follows:

- **Endometriosis** – initial 6 month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course.
- **Uterine leiomyomata** – 3 month approval.
- **Advanced prostate cancer** – initial 6 month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

Preferred

☐ Lupron Depot

Strength	Dosage Instructions	Quantity	Days Supply

Setting to be administered:

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

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☐ **Endometriosis**. Payment will be considered for patients for whom therapy with NSAIDs and at least one preferred 3 month course of a continuous hormonal contraceptive has failed.

NSAID trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

Continuous hormonal contraceptive trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

Renewal requests only:

Will member be prescribed concomitant norethindrone acetate 5mg daily? ☐ No ☐ Yes

☐ **Uterine Leiomyomata**. Payment will be considered for patients with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively.

Iron trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

Most recent Hematocrit Level:_____ Date this level was obtained:_____

Most recent Hemoglobin Level:_____ Date this level was obtained:_____

Is Lupron Depot to be used preoperatively? ☐ No ☐ Yes

☐ **Advanced Prostate Cancer**

Renewal requests only:

Most recent Testosterone Level (attach results):_____
Date this level was obtained:_____

☐ **Other Diagnosis**_____

Possible drug interactions/conflicting drug therapies/other medical conditions to consider:_____

_____

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.*