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Online

covermymeds.com/main/ prior-authorization-forms/

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 \geq 11 years of age for females and \geq 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

Preferred

Non-Preferred

Lupron Depot-Ped (1-Month)

Lupron Depot-Ped (3-Month)

Strength	Dosage Instructions	Quantity	Days Supply	
Diagnosis:				



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Patient has documentation	on of onset of	f secondary sexual	characteristics	earlier than 8	years in females and 9
years in males? 🗌 No					

Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test?

Documentation	of advance	ced bone a	age (defined	l as ≥ two	standard	deviations	above the	e gender/ag	e related
mean)?	🗌 No	🗌 Yes (attach resul	ts)					

Baseline evaluations:

Height:	Date obtained:			
Weight:	Date obtained:			
Sex steroid (testosterone/est	radiol) levels obtained? 🗌 No 📄 Yes (attach results)			
Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor?				
Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors?				
Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor?				
Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia?				
Setting to be administered:				
Age override consideration				

Documentation of medical necessity for continued treatment beyond the following ages: females \geq 11 years of age and males \geq 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.