05/02/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Lupron Depot (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Lupron Depot (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Lupron Depot 1-month 3.75 mg (leuprolide acetate)
Lupron Depot 3-month 11.25 mg (leuprolide acetate)
Lupron Depot-Ped
Quantity _____ Frequency _____ Strength _____
Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 18.]

2. Does the patient meet all of the following? Y N

   Patient is 18 years of age or older \ The requested drug is prescribed by or consultation with a gynecologist or obstetrician

   [If no, skip to question 8.]

3. Does the patient have a diagnosis of endometriosis? Y N

   [If no, skip to question 6.]

4. Has the patient had a trial and failure of at least one formulary medication unless contraindicated (i.e., medroxyprogesterone or other hormonal cycle control agents [e.g., Portia, Ocella])? Please indicate which formulary medications patient failed (if patient has a contraindication, please indicate drug and contraindication): Y N

   [If no, no further questions.]

5. Is the request for Lupron Depot? Y N

   [No further questions]

6. Does the patient have a diagnosis of anemia due to uterine leiomyomata (fibroids) and plan for surgical intervention (within 3-6 months)? Y N

   If yes, please document date surgery is scheduled:

   [If no, no further questions.]

7. Has the patient completed 3 months of treatment with Lupron Depot? Y N

   [No further questions.]

8. Is the request for Lupron Depot-PED? Y N

   [If no, skip to question 16.]

9. Does the patient have a diagnosis of central precocious puberty (CPP)? Y N

   [If no, no further questions.]

10. Is therapy prescribed by or in consultation with an endocrinologist? Y N

    [If no, no further questions.]

11. Has an MRI or CT scan been performed to rule out lesions? Y N

    [If no, no further questions.]

12. Did the patient have onset of secondary sexual characteristics earlier than 8 years of age for a female patient and 9 years of age for a male patient? Y N

    [If no, no further questions.]

13. Has the diagnosis been confirmed by a response to a GnRH stimulation test, or if not available, other labs to support the diagnosis of CPP? If yes, document test results and date drawn: Y N

    [If no, no further questions.]

14. Is the patient's bone age advanced at least 1 year beyond the chronological age? If yes, document date of test, chronological age at the time of test, and bone age: Y N

    [If no, no further questions.]

15. Is the patient at least 2 years old? Y N

    [No further questions.]

16. Does the patient have a diagnosis of prostate cancer? Y N

    [If no, no further questions.]

17. Does the patient meet all of the following? Y N

    Does the patient meet all of the following?

    [No further questions.]

18. Is the request for Lupron Depot-PED? Y N

    [If yes, skip to question 25.]

19. Does the patient have a diagnosis of endometriosis? Y N

    [If no, skip to question 23.]

20. Will Lupron Depot be used in combination with norethindrone acetate 5 mg daily? Y N

    [If no, no further questions.]

Y N

21. Does the patient have bone density values (DEXA or BMD) within normal limits? Please provide date of Bone Density exam and result Y N

    [If no, no further questions.]

22. Has the patient completed an original 6-month course of treatment followed by an additional 6 months of treatment (1 year total)? Y N

    [No further questions]

23. Does the patient have a diagnosis of anemia due to uterine leiomyomata (fibroids)? Y N

    [If no, no further questions.]

24. Has the patient completed 3 months of treatment with Lupron Depot? Y N

    [No further questions.]

25. Does the patient have a diagnosis of central precocious puberty (CPP)? Y N

    [If no, no further questions.]

26. Is the patient demonstrating a clinical response to treatment as demonstrated by any of the following? Please document all that apply: Y N

    Pubertal slowing or decline \ Suppression of FSH, LH, estradiol/testosterone levels \ Normalization of bone age

    [If no, no further questions.]

27. Does the patient meet one of the following? Y N

Female patient who is less than11 years of age \ Male patient who is less than 12 years of age

[No further questions.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**