

Print Form



Aetna Better Health® of Florida (MEDICAID)

Supprelin LA (histrelin acetate)

Maximum Length of Therapy = Date of Service

Note: Form must be completed in full. An incomplete form may

be returned.

Recipient's Medicaid ID#	Date of Birth (MM/DD/YY	YY)	
Recipient's Full Name			
Prescriber's Full Name			
Prescriber's NPI			
Prescriber's Phone Number		Prescriber's Fax Number	
			-
Prescriber Specialty:			
1. Is this medication for precocious pube	rtv?		
☐ Yes ☐ No	· ·		
If <i>YES</i> , specify ICD:			
2. Is the prescriber a pediatric endocrino	loaist?		
3. Has the patient had a clinical course o (within the last six months)?	f either Lupron Depot-Pe	d or Synarel that has failed or	was not tolerated
Yes No			
Note: Legible copies of progress notes describing these events are required, please attach.			
		· · · · · · · · · · · · · · · · · · ·	
Please submit measurement of blood conce	ntration of total sex stero	ids, measurement of LH and F	SH after
stimulation with GnRH analog, and assessment of bone versus chronological age.			
Prescriber's Signature:		Date:	

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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