Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Leuprolide (Medicaid)

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 at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Leuprolide (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Leuprolide acetate solution for injection

Other, Please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

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

   [If no, skip to question 11.]

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

   [If yes, skip to question 9.]

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

   [If no, no further questions.]

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

   [If no, no further questions.]

5. 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.]

6. 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 (ie, luteinizing hormone levels, estradiol and testosterone level)? Y N

   If yes, document test results and date drawn:_____

   [If no, no further questions.]

7. Is the patient's bone age advanced at least 1 year beyond the chronological age? Y N

   If yes, document date of test, chronological age at the time of test, and bone age:

   _____

   [If no, no further questions.]

8. Has a baseline height, weight and LH levels been provided? Y N

   Please document date, height, weight and LH levels:_____

   [No further questions.]

9. Is the patient demonstrating a clinical response to treatment as demonstrated by any of the following? A) Pubertal slowing or decline, B) Suppression of FSH, LH, estradiol/testosterone levels, or C) Normalization of bone age/height velocity Y N

   Please document all that apply:

   _____

   [If no, no further questions.]

10. Does the patient meet one of the following? A) Female patient who is less than 11 years of age, or B) Male patient who is less than 12 years of age Y N

[No further questions.]

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

[If no, no further questions.]

12. Is the patient at least 18 years old?' Y N

[If no, no further questions.]

13. Is the requested drug prescribed by or in consultation with an oncologist or urologist? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date