Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Synarel (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 Synarel (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Synarel (nafarelin acetate nasal solution)

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

   [If yes, then skip to question 9.]

2. Does the patient have a diagnosis of Central Precocious Puberty (CPP)? Y N

   [If yes, then skip to question 12.]

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

   [If no, then no further questions.]

4. Is Synarel being prescribed by or in consultation with a gynecologist or obstetrician? Y N

   [If no, then no further questions.]

5. Does the patient have a diagnosis of Endometriosis? Y N

   [If no, then skip to question 7.]

6. Has the patient had a trial and failure of at least one formulary hormonal cycle control agent (such as ethinyl estradiol plus levonorgestrel, ethinyl estradiol plus drospirenone, or ethinyl estradiol plus norgestimate), medroxyprogesterone, or Danazol? Y N

   If yes, please indicate which medications patient failed:

   _____

   [If no, then no further questions.]

   [If yes, then skip to question 8.]

7. Is Synarel being prescribed for uterine fibroids to either improve anemia or reduce uterine size before planned surgical intervention within the next 3 to 6 months? Y N

   If yes, please document surgery date:

   _____

   [If no, then no further questions.]

8. Has the patient already received 6 months of treatment with Synarel? Y N

   [No further questions.]

9. Does the patient have a diagnosis of Central Precocious Puberty (CPP)? Y N

   [If no, then skip to question 19.]

10. 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, C) Normalization of bone age/height velocity? Y N

    If yes, please document all that apply:

    _____

    [If no, then no further questions.]

11. Does the patient meet one of the following: female patient who is less Y N

than 11 years of age OR male patient who is less than 12 years of age?

[No further questions.]

12. Is Synarel prescribed by or in consultation with an endocrinologist? Y N

[If no, then no further questions.]

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

[If no, then no further questions.]

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

[If no, then no further questions.]

15. 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 (i.e., luteinizing hormone levels, estradiol and testosterone level)? Y N

If yes, document test results and date drawn:_____

[If no, then no further questions.]

16. 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, then no further questions.]

17. Has a baseline height, weight and LH level been provided? Y N

If yes, please document date, height, weight and LH levels:

_____

[If no, then no further questions.]

18. Does the patient meet one of the following: female patient who is less than 11 years of age OR male patient who is less than 12 years of age? Y N

[No further questions.]

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

[If no, then no further questions.]

20. Is surgical intervention scheduled? Y N

If yes, please document date of planned surgery:

_____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date