Gonadotropin-Releasing Hormone (GnRH)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	

Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.

For treatment of Gender Dysphoria, please refer to the Gender Dysphoria prior authorization form

Criteria for Approval: *(at least one of the following criteria must be met)*

Indication:

- ❑ Anemia caused by uterine fibroids (concomitantly with iron therapy)
- ❑ Breast Cancer
- ❑ Central Precocious Puberty
- ❑ Endometriosis
- ❑ Ovarian Cancer
- ❑ Premenstrual Syndrome
- ❑ Prostate Cancer, advanced (palliative treatment)
- ❑ Uterine Fibroids
- ❑ Puberty suppression for Gender Dysphoria

Additional Criteria for Fensolvi (at least ONE of the following must be met):

- ❑ Trial and failure of Eligard 45mg (leuprolide acetate depot subQ injection):
  Details of failure: ______________________________
  Date of Use: ______________ Duration of Use: ______________
  Chart Note Page #: ________
- ❑ Detailed evidence of a condition or contraindication that prevents the use of Eligard.
  Chart Note Page #: ________
- ❑ Clinical evidence that patient is high risk or adverse events due to a therapeutic interchange with Eligard.
  Chart Note Page # ________

Additional Criteria for Puberty Blocker (ALL must be met):

- ❑ The patient is less than 18 years of age (This criteria does not apply to individuals 18 years of older)
- ❑ The patient was diagnosed with gender dysphoria prior to January 28, 2023. Documentation demonstrates the date of diagnosis: _____________
- ❑ Documentation demonstrates that the provider has been treating the patient for gender dysphoria for at least 6 months.

Re-authorization Criteria for indications OTHER THAN gender dysphoria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Re-authorization Criteria for Gender Dysphoria:
Updated chart notes demonstrating positive clinical response

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

______________________________________ ______________

Prescriber's Signature Date