pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

PITUITARY SUPPRESSIVE AGENTS, LHRH PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Pituitary Suppressive Agents, LHRH** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	Total # of pgs: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested ***(clinical prior authorization required)*:**	**Non-preferred medication requested:**
☐Eligard kit ☐Lupron Depot kit ☐Lupron Depot-Ped 1-month kit ☐Synarel nasal ☐Trelstar ☐Triptodur kit ☐Vantas kit ☐Zoladex implant	☐leuprolide acetate vial kit ☐Lupaneta Pack kit ☐Lupron Depot-Ped 3-month kit ☐Orilissa tablet ☐Supprelin LA kit ☐____________________

Product strength & frequency:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Pituitary Suppressive Agents, LHRH (*except Lupaneta Pack and Synarel nasal*), are part of the DHS Specialty Pharmacy Drug Program (SPDP). What specialty pharmacy will be used?
   ☐Diplomat Specialty Pharmacy
   ☐Walgreen's Specialty Pharmacy

2. Is the beneficiary being treated for one of the following diagnoses? *Check all that apply.*
   ☐advanced prostate cancer ☐endometriosis ☐gender dysphoria
   ☐central precocious puberty (CPP) ☐uterine fibroids ☐breast cancer
   ☐Yes – *Submit documentation of diagnosis.*
   ☐No – *Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.*

3. ***For requests for a NON-PREFERRED agent***, does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred agents in this class that are indicated or recommended for the treatment of the beneficiary's diagnosis? *Check all that apply and submit documentation of medication regimen and associated trial and failure, contraindication, or intolerances.*

ADVANCED PROSTATE CANCER
☐Eligard kit
☐Lupron Depot kit
☐Trelstar
☐Vantas kit
☐Zoladex implant

ENDOMETRIOSIS
☐Lupron Depot kit
☐Synarel nasal
☐Zoladex implant

UTERINE FIBROIDS
☐Lupron Depot kit

CENTRAL PRECOCIOUS PUBERTY (CPP)
☐Lupron Depot kit
☐Lupron Depot-Ped kit 1-month (7.5 mg, 11.25 mg, or 15 mg)
☐Synarel nasal
☐Triptodur kit

ALL OTHER DIAGNOSES
☐Eligard
☐Lupron Depot kit
☐Lupron Depot-Ped kit 1-month (7.5 mg, 11.25 mg, or 15 mg)
☐Synarel nasal
☐Trelstar
☐Vantas kit
☐Zoladex implant

4. ***For the treatment of gender dysphoria in adolescent beneficiaries***, if the prescriber is NOT a pediatric endocrinologist, adolescent medicine specialist, or medical provider with experience and/or training in transgender medicine, is the requested medication being prescribed *in consultation with* one of these specialists?
   ☐Yes – *Submit documentation of consultation.*
   ☐No or not applicable

5. ***For the treatment of gender dysphoria in adolescent beneficiaries***, is the requested agent being prescribed in a manner consistent with the current World Professional Association for Transgender Health (WPATH) standards of care for the health of transsexual, transgender, and gender nonconforming people?
   ☐Yes – *Submit documentation.*
   ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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