

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: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pgs: _____		Prescriber name:	
Name of office contact:				Specialty:	
Contact's phone number:				NPI:	State license #:
LTC facility contact/phone:				Street address:	
Beneficiary name:				Suite #:	City/State/Zip:
Beneficiary ID#:		DOB:	Phone:		Fax:

CLINICAL INFORMATION

Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

Drug requested:		Strength:	
Directions/frequency:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	
For a non-preferred Pituitary Suppressive Agent, LHRH: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class approved or medically accepted for treatment of the beneficiary's condition? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.		<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No	

Complete the section(s) below applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- For the treatment of gender dysphoria:**
- Is prescribed the medication by or in consultation with an adult or peds endocrinologist or other provider with experience/training in transgender medicine
 - Is prescribed the medication in a manner consistent with current WPATH standards of care or other medical literature
- For the treatment of endometriosis:**
- Is prescribed the medication by or in consultation with a gynecologist
 - Diagnosis confirmed by laparoscopy
 - Diagnosis supported by chart documentation of adequate work-up that includes the clinical rationale for the diagnosis
 - Tried and failed NSAIDs or has a contraindication or intolerance to NSAIDs
 - Failed a 3-month trial of oral contraceptives or has a contraindication or intolerance to oral contraceptives
- For Orilissa (elagolix) for a beneficiary with a history of depression and/or suicidal thoughts or behaviors or who is currently being treated for depression and/or suicidal thoughts or behavior:**
- Had a behavioral health assessment prior to use of Orilissa

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

Prescriber Signature:	Date:
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