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 *(form effective 1/3/2022)*

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.

☐New request ☐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 *(submit documentation)*:	Dx code (*required*):	
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 drugs 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.*	☐Yes – *Submit documentation.* ☐No	

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

☐**For the treatment of CENTRAL PRECOCIOUS PUBERTY:**
- ☐Is prescribed the medication by or in consultation with a pediatric endocrinologist
- ☐Is female:
  - ☐Is ≤11 years of age
  - ☐Experienced onset of secondary sexual characteristics earlier than 8 years of age
- ☐Is male:
  - ☐Is ≤12 years of age
  - ☐Experienced onset of secondary sexual characteristics earlier than 9 years of age

☐**For the treatment of GENDER DYSPHORIA:**
- ☐Is prescribed the medication by or in consultation with an adult or pediatric 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

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☐ 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 PRESERVATION OF OVARIAN FUNCTION:**
☐ Is receiving cancer treatment that is associated with premature ovarian failure based on NCCN guidelines or peer-reviewed medical literature

☐ **For MYFEMBREE (relugolix/estradiol/norethindrone), ORIAHNN (elagolix/estradiol/norethindrone + elagolix), and ORILISSA (elagolix):**
☐ Has a history of depression and/or suicidal thoughts or behaviors OR is receiving treatment for depression and/or suicidal thoughts or behaviors
☐ Had a behavioral health assessment prior to use of the requested medication

☐ **For MYFEMBREE (relugolix/estradiol/norethindrone) and ORIAHNN (elagolix/estradiol/norethindrone + elagolix):**
☐ Is being treated for **HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS)**
☐ Is pre-menopausal
☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to contraceptives

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

Prescriber Signature:	**Date**: