CVS caremark™ {{PANUMCODE}}

Lupron Hormonal Therapy

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. Which drug and strength is being prescribed?
   - ❑ Lupron Depot 7.5 mg
   - ❑ Lupron Depot-3 month 22.5 mg
   - ❑ Lupron Depot-4 month 30 mg
   - ❑ Lupron Depot-6 month 45 mg
   - ❑ Lupron Depot 3.75 mg
   - ❑ Lupron Depot-3 month 11.25 mg
   - ❑ Lupaneta Pack
   - ❑ leuprolide acetate depot 3-month 22.5 mg
   - ❑ Lupron Depot-**PED** 7.5 mg
   - ❑ Lupron Depot-**PED-1 month** 11.25 mg
   - ❑ Lupron Depot-**PED-3 month** 11.25 mg
   - ❑ Lupron Depot-**PED** 15 mg
   - ❑ Lupron Depot-**PED** 30 mg
   - ❑ Lupron Depot-**PED-6 month** 45 mg
   - ❑ leuprolide kit
   - ❑ Other _____

   Indicate prescribed dose and frequency: _____

2. What is the requested drug being used for? *Indicate ALL that apply.*
   - ❑ Uterine leiomyomata (fibroids)
   - ❑ Endometriosis
   - ❑ Primary peritoneal cancer
   - ❑ Fallopian tube cancer
   - ❑ Central precocious puberty (CPP)
   - ❑ Grade 1 endometrioid carcinoma
   - ❑ Low-grade serous carcinoma
   - ❑ Mucinous carcinoma of the ovary
   - ❑ Mature oocyte cryopreservation
   - ❑ Preimplantation genetic diagnosis
   - ❑ Epithelial ovarian cancer
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ Recurrent salivary gland tumors
   - ❑ Salivary gland tumors
   - ❑ Treatment of advancing puberty and growth failure
   - ❑ Carcinosarcoma (malignant mixed Müllerian tumors)
   - ❑ Clear cell carcinoma of the ovary
   - ❑ Embryo cryopreservation
   - ❑ Recurrent menstrual related attacks in acute porphyria
   - ❑ Preservation of ovarian function in patients with cancer
   - ❑ Ovarian cancer-Malignant sex cord-stromal tumors (granulosa cell tumors)
   - ❑ Use as stimulation test to confirm the diagnosis of central precocious puberty (CPP)
   - ❑ Ovulation induction (e.g., intrauterine insemination [IUI])
   - ❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection (ICSI))
   - ❑ Other _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

3. What is the ICD-10 code? _____

Section A: Preferred Product ***If the request is for Lupron Depot***

4. Is the product being requested for the treatment of prostate cancer or a uterine disorder?
   ❑ Yes, prostate cancer ❑ Yes, a uterine disorder, *skip to diagnosis section* ❑ No, *skip to diagnosis section*

5. The preferred product for your patient's health plan is Eligard. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes, ***please indicate:*** _____ ❑ No - Continue request for non-formulary medication.

6. Does the patient have a documented hypersensitivity to the preferred product (Eligard)? ***ACTION REQUIRED: If Yes, submit supporting chart note(s).*** ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section B: Central Precocious Puberty

7. Is the patient currently receiving the prescribed therapy for central precocious puberty through a paid pharmacy or medical benefit? ❑ Yes ❑ No *If No, skip to #9*

8. Is the patient experiencing signs of treatment failure (e.g., clinical pubertal progression, lack of growth deceleration and continued excessive bone age advancement)? ❑ Yes ❑ No

9. Has the patient been evaluated for intracranial tumor(s) by appropriate lab tests and diagnostic imaging (e.g., computed tomography (CT scan), magnetic resonance imaging (MRI))? ❑ Yes ❑ No

10. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a gonadotropin-releasing hormone (GnRH) agonist test **or** a pubertal level of a third generation luteinizing hormone (LH) assay? ***ACTION REQUIRED: If Yes, collect laboratory report or medical record of pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay.*** ❑ Yes ❑ No

11. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty? ❑ Yes ❑ No

12. How old was the patient **AT THE ONSET** of secondary sexual characteristics? _____ years

Section C: Uterine Leiomyomata (Fibroids)

13. Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
    ❑ Yes ❑ No *If No, skip to #15*

14. How long has the patient received previous therapy with Lupron Depot and Lupaneta Pack? _____ months
    Indicate dates and doses received: _____

15. Does the patient have a diagnosis of anemia due to uterine leiomyomata? (for example, Hct less than or equal to 30% and/or Hgb less than or equal to 10 g/dL). *If Yes, no further questions.* ❑ Yes ❑ No
    Provide at least one lab value and date drawn:
    Hematocrit (Hct): _____ % Date drawn: _____
    Hemoglobin (Hgb): _____ g/dL Date drawn: _____

16. Will the requested drug be used prior to surgery for uterine leiomyomata (fibroids)? ❑ Yes ❑ No

Section D: Endometriosis

17. Has the patient received previous therapy with Lupron Depot or Lupaneta Pack?
    ❑ Yes ❑ No *If No, no further questions.*

18. Has the patient had a recurrence of symptoms? ❑ Yes ❑ No *If No, no further questions*

19. Is the patient's bone mineral density within normal limits? ❑ Yes ❑ No *If No, no further questions*

20. How long has the patient received previous therapy with Lupron Depot and Lupaneta Pack? _____ months
    Indicate dates and doses received: _____

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Section E: Treatment of Advancing Puberty and Growth Failure

21. Is the patient also requesting or is currently receiving growth hormone? ❑ Yes ❑ No

Section F: Salivary Gland Tumors, Recurrent Salivary Gland Tumors and Prostate Cancer

22. *If the diagnosis is salivary gland tumors,* does the patient have recurrent disease? ❑ Yes ❑ No

23. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No
For salivary gland tumors and recurrent salivary gland tumors requests: *If No, skip to #27*
For prostate cancer requests: *If No, no further questions.*

24. *If the diagnosis is recurrent salivary gland tumors,* has the patient experienced clinical benefit to therapy while on the current regimen? ❑ Yes ❑ No

25. *If the diagnosis is prostate cancer,* has the patient experienced clinical benefit to therapy while on the current regimen (e.g., serum testosterone less than 50 ng/dL)? ❑ Yes ❑ No

26. Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?
❑ Yes ❑ No *No further questions.*

27. *If the diagnosis is recurrent salivary gland tumors,* is the tumor androgen receptor positive?
❑ Yes ❑ No *If No, no further questions*

28. *If the diagnosis is recurrent salivary gland tumors,* will the requested drug be used as a single agent?
❑ Yes ❑ No

Section G: Preservation of Ovarian Function

29. Is the patient premenopausal and undergoing chemotherapy? ❑ Yes ❑ No

Section H: Prevention of Recurrent Menstrual Related Attacks in Acute Porphyria

30. Is the requested drug being requested to prevent recurrent menstrual related attacks in acute porphyria?
❑ Yes ❑ No

31. Is the requested drug prescribed by, or in consultation with, a physician experienced in the management of porphyrias? ❑ Yes ❑ No

Section I: Epithelial Ovarian Cancer, Fallopian Tube Cancer, Primary Peritoneal Cancer, Ovarian Cancer-Malignant Sex Cord-Stromal Tumors (granulosa cell tumors), Breast Cancer, Grade 1 Endometrioid Carcinoma, Low-Grade Serous Carcinoma, Carcinosarcoma (Malignant Mixed Müllerian Tumors), Mucinous Carcinoma of the Ovary, Clear Cell Carcinoma of the Ovary

32. *If the diagnosis is breast cancer,* what is the patient's hormone receptor (HR) status?
If positive, skip to #35 ❑ Positive ❑ Negative ❑ Unknown

33. Does the patient have persistent or recurrent disease? ❑ Yes ❑ No

34. Will the requested medication be used as a single agent? ❑ Yes ❑ No

35. Is the patient currently receiving treatment with the requested drug?
❑ Yes ❑ No *If No, no further questions.*

36. Has the patient experienced an unacceptable toxicity or disease progression while on the current regimen?
❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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