



Supprelin LA

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at 1-844-387-1435.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un
Directions(sig) _____ Route of administration _____
Dosing frequency _____

Criteria Questions:

1. What is the diagnosis?
 Central precocious puberty (CPP) Gender dysphoria Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis.

Section A: Central Precocious Puberty (CPP)

3. Is the patient currently receiving the prescribed therapy for central precocious puberty?
If Yes, no further questions Yes No
4. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a GnRH (gonadotropin-releasing hormone) agonist test **or** a pubertal level of a third generation LH (luteinizing hormone) assay? Yes No
5. Has the diagnosis been confirmed by assessment of bone age versus chronological age? Yes No
6. How old was the patient **AT THE ONSET** of secondary sexual characteristics? _____ years

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Supprelin LA with TGC SGM – 06/2018.

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Section A: Gender Dysphoria

7. What is the patient's physical developmental stage?
 Patient has NOT completed puberty
 Patient has completed puberty, *skip to #10*
8. Is Supprelin LA prescribed for pubertal suppression in preparation for gender reassignment? Yes No
9. Which Tanner Stage of puberty has the patient reached? *Indicate below and no further questions.*
 I II III IV V Unknown
10. Is the patient undergoing gender reassignment? Yes No
11. Will the patient receive Supprelin LA concomitantly with cross sex hormones? 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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