Prior Authorization Criteria Form

This form applies to Paramount Advantage and Paramount Commercial Members Only

Lupron Depot-Endometriosis

Complete/review information, sign and date. Please fax signed forms to Paramount at 1-844-256-2025. You may contact Paramount by phone at 1-419-887-2520 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Lupron Depot-Endometriosis.

Drug Name (select from list of drugs shown)
- Leuprolide Acetate 3.75mg
- Lupron Depot 3.75mg
- Lupron Depot-3 Month 11.25mg
Other, Please specify

Quantity ____________ Frequency ____________ Strength ____________

Route of Administration ____________ Expected Length of Therapy ____________

Patient Information
- Patient Name: ____________________________
- Patient ID: ____________________________
- Patient Group No.: ____________________________
- Patient DOB: ____________________________
- Patient Phone: ____________________________

Prescribing Physician
- Physician Name: ____________________________
- Physician Phone: ____________________________
- Physician Fax: ____________________________
- Physician Address: ____________________________
- City, State, Zip: ____________________________

Diagnosis: ____________________________ ICD Code: ____________________________

Comments: ____________________________

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of endometriosis? Y N
   [If no, skip to question 9.]

2. Is this a request for endometriosis retreatment? Y N
   [If no, skip to question 7.]

3. Has the patient had a recurrence of symptoms? Y N
   [If no, no further questions.]

4. Has the patient previously received a 6-month RETREATMENT course of therapy? Y N
   [If yes, no further questions.]

5. Will the patient be receiving add-back therapy (e.g., norethindrone)? Y N
   [If yes, skip to question 18.]
   [If no, no further questions.]

6. Does the patient have a diagnosis of uterine fibroids? Y N
   [If no, skip to question 11.]
7. Is Lupron Depot being used in the preoperative setting to facilitate surgery?  
   [If yes, skip to question 9.]
8. Does the patient have a diagnosis of anemia (i.e., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10 grams per deciliter)?  
   [If no, no further questions.]
9. Is this a request for uterine fibroids retreatment?  
   [If no, n of further questions.]
10. Has the patient previously received a 3-month retreatment course of therapy?  
    [If no, skip to question 18.]  
    [If yes, no further questions.]
11. Does the patient have a diagnosis of ovarian stromal tumor(s)?  
    [If yes, skip to question 18.]
12. Does the patient have a diagnosis of ANY of the following cancers: Epithelial ovarian cancer, Fallopian tube cancer, Primary peritoneal cancer?  
    [If no, skip to question 15.]
13. Is the disease persistent or recurrent?  
    [If no, no further questions.]
14. Will Lupron Depot be used as a single agent?  
    [If yes, skip to question 17.]  
    [If no, no further questions.]
15. Does the patient have a diagnosis of breast cancer?  
    [If no, no further questions.]
16. Is the request for a premenopausal patient with hormone receptor positive disease?  
    [If no, no further questions.]
17. Is the request for Lupron Depot 3.75mg?  
    [If no, no further questions.]
18. Is the patient 18 years of age or older?  
    Y  N

I affirm that the information given on this form is true and accurate as of this date.

_______________________________
Prescriber (Or Authorized) Signature and Date