



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Pituitary Suppressive Agents - LHRH

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug for an indication that is included in the United States (U.S.) Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

Yes

No

Q2. Is the requested drug prescribed at a dose and duration of therapy that is consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q3. Does the patient have a history of a contraindication to the prescribed medication?

Yes

No

Q4. Is the patient age-appropriate for the requested drug according to the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q5. For diagnosis of central precocious puberty, the medication prescribed by or in consultation with a pediatric endocrinologist?

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. For a diagnosis of central precocious puberty, is the patient <11 years of age for females or <12 years of age for males?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. For a diagnosis of central precocious puberty, has the patient developed the onset of secondary sexual characteristics earlier than 8 years of age in females and 9 years of age in males?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have a diagnosis of gender dysphoria?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is the patient an adolescent?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Is the requested drug prescribed by or in consultation with a pediatric endocrinologist, adolescent medicine specialist, or medical provider with experience and/or training in transgender medicine?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Is the patient an adult?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Is the requested drug prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine?	



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is the requested drug prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transgender and gender diverse people?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Does the patient have a diagnosis of endometriosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is the diagnosis of endometriosis confirmed by laparoscopy OR supported by chart documentation of an adequate work-up that includes the clinical rationale for the diagnosis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Does the patient have a history of therapeutic failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs), AND therapeutic failure (based on a 3-month trial), contraindication, or intolerance to oral contraceptives?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Is the requested drug prescribed by or in consultation with a gynecologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Is the requested drug being used for the preservation of ovarian function?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Is the patient receiving cancer treatment that is associated with premature ovarian failure (based on NCCN guidelines or peer-reviewed medical literature)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Is the requested drug Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone)?	

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q22. Is Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone) being used for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal woman?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q23. Does the patient have a history of therapeutic failure (based on a 3-month trial), contraindication, or intolerance of contraceptives?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q24. Does the patient have a history of depression and/or suicidal thoughts or behaviors or is currently receiving treatment for depression and/or suicidal thoughts or behavior?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q25. Has a behavioral health assessment been performed prior to use of Oriahnn (elagolix, estradiol, norethindrone, elagolix) or Myfembree (relugolix/estradiol/norethindrone)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q26. Is the requested drug a non-preferred agent?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q27. Does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Pituitary Suppressive Agents, LHRH approved or medically accepted for the patient's indication?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q28. Additional Information:</p>	

 Prescriber Signature

 Date



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