



Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Leuprolide Acetate
Lupron Depot (leuprolide acetate depot), Lupron Depot-PED (leuprolide acetate) Fensolvi (leuprolide acetate)
Firmagon (degarelix acetate)
Supprelin LA (histrelin acetate)
Triptodur (triptorelin pamoate)
Vantas (histrelin acetate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication requested: Fensolvi: <input type="checkbox"/> 45mg (pediatric 6 month) Firmagon: <input type="checkbox"/> 80mg <input type="checkbox"/> 120mg Leuprolide acetate <input type="checkbox"/> 1mg/0.2ml Lupron Depot: <input type="checkbox"/> 3.75mg <input type="checkbox"/> 7.5mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 30mg <input type="checkbox"/> 45mg Leuprolide acetate depot: <input type="checkbox"/> 22.5mg Lupron Depot-PED: <input type="checkbox"/> 7.5mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg <input type="checkbox"/> 45mg Supprelin LA: <input type="checkbox"/> 50mg kit Triptodur: <input type="checkbox"/> 22.5mg Vantas: <input type="checkbox"/> 50mg kit Dose: _____ Frequency of administration: _____ J-Code: _____ ICD10: _____ Patient weight: _____ kg or _____ lbs					
Where will this medication be obtained? <input type="checkbox"/> Panther Rx (for Triptodur only) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Maxor National Pharmacy (for Fensolvi only) <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Accredo Specialty Pharmacy** <i>**Cigna's nationally preferred specialty pharmacy</i> <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					

Where will this drug be administered?

- Patient's Home Physician's Office
 Hospital Outpatient Other (please specify):

NOTE: Per some Cigna plans, infusion of medication **MUST** occur in the *least intensive, medically appropriate setting*.

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? Yes No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes No

Diagnosis related to use (please specify):

- abnormal uterine bleeding
- breast cancer
- treatment of central precocious puberty (CPP)
- stimulation test to confirm central precocious puberty (CPP) before starting treatment
- endometriosis
- epithelial cell (carcinoma)/epithelial ovarian cancer
- fallopian tube cancer
- gender-dysphoric/gender-incongruent persons (formerly known as gender identity disorder or GID))
- gender reassignment surgery
- hirsutism
- infertility
- menstrual migraines
- ovarian sex cord-stromal tumor (granulosa cell tumor, fibroma-thecoma, fibroma, thecoma, Sertoli-Leydig cell tumor)
- polycystic ovarian syndrome (PCOS)
- premenstrual syndrome (PMS)
- peripheral precocious puberty (gonadotropin-releasing hormone-independent precocious puberty)
- primary peritoneal cancer
- prostate cancer
- salivary gland cancer
- uterine fibroids or leiomyomata
- other (please specify):

Is this new start or continuation of therapy with this drug? new start continued therapy

(if continued therapy) Is there documentation of a beneficial response to this medication? Yes No

(if Lupron Depot [leuprolide acetate depot] and continued therapy for uterine fibroids or leiomyomata) Has your patient already received 3 months of treatment? Yes No

(if Lupron Depot [leuprolide acetate depot] and not received 3 months) How many months of therapy has your patient received?

Clinical Information:

(if breast) Does your patient have hormone receptor-positive breast cancer? Yes No

(if breast) Has your patient reached menopause? Yes No

(if CPP) Has the diagnosis been confirmed by a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.3mIU/mL? Yes No

(if CPP, LH level NOT greater than or equal to 0.3mIU/mL) Has the diagnosis been confirmed by a pubertal luteinizing hormone (LH) response to a GnRH stimulation test? Yes No

(if CPP and male patient) Was the onset of secondary sexual characteristics earlier than 9 years of age? Yes No

(if CPP and female patient) Was the onset of secondary sexual characteristics earlier than 8 years of age? Yes No

(if epithelial) Which of the following applies to your patient?

- patient has persistent disease
- patient has recurrent disease
- none of the above

(if none of the above) Which type of epithelial cancer does your patient have?

- Clear cell carcinoma
- Endometrioid carcinoma
- Serous carcinoma
- Mucinous Carcinoma
- Unknown or Other

(if epithelial, serous) Is the tumor low-grade or high-grade?

- low-grade high-grade

(if epithelial, serous or endometrioid) Will the requested medication be used as adjuvant therapy (to keep the cancer from coming back)? Yes No

(if fallopian tube or peritoneal) Does your patient have persistent or recurrent disease? Yes No

(if gender-dysphoric/gender-incongruent or gender reassignment) Is this medication prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender individuals? Yes No

(if infertility) What infertility service is your patient undergoing? (e.g. IUI, IVF, GIFT, ZIFT, etc)

(if infertility) Will the requested medication be used in combination with urofollitropin or menotropins in a woman with premature luteinizing hormone (LH) surge? Yes No

(if yes) Will the requested drug be used to suppress luteinizing hormone (LH) production? Yes No

(if infertility) Will the patient undergo in vitro fertilization (IVF)? Yes No

(if yes) Will the requested medication be used to prevent severe ovarian hyperstimulation syndrome (OHSS)? Yes No

(if ovarian sex cord-stromal) Does your patient have relapsed disease? Yes No

(if prostate) Does your patient have advanced disease? Yes No

(if prostate and Firmagon or Vantas only) Is the requested medication being used as adjuvant therapy? Yes No

(if salivary gland) Does your patient have recurrent disease? Yes No

(if salivary gland) Does your patient have distant metastases? Yes No

Additional Pertinent Information: *(please include clinical reasons for drug, relevant lab values, etc. Where applicable, please include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v010124

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005