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

Lupron Depot, Lupron Depot-PED (leuprolide acetate)
Lupaneta (leuprolide/Norethindrone 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:
☐ Standard ☐ 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:	☐ 45mg (pediatric 6 month)					
Firmagon:	☐ 80mg	☐ 120mg				
Lupaneta Pack:	☐ 1-month 3.75mg-5mg Kit		☐ 3-month 11.25mg-5mg Kit			
Lupron Depot:	☐ 3.75mg	☐ 7.5mg	☐ 11.25mg	☐ 22.5mg	☐ 30mg	☐ 45mg
Lupron Depot-PED:	☐ 7.5mg	☐ 11.25mg	☐ 15mg	☐ 30mg		
Supprelin LA:	☐ 50mg kit					
Triptodur:	☐ 22.5mg					
Vantas:	☐ 50mg kit					

Dose: Frequency of administration:
J-Code: ICD10:

Where will this medication be obtained?
☐ Panther Rx (for Triptodur only) ☐ Home Health / Home Infusion vendor
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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
☐ infertility
☐ ovarian sex cord-stromal tumor (granulosa cell tumor, fibroma-thecoma, fibroma, thecoma, Sertoli-Leydig cell tumor)
☐ 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) Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No

(if Lupaneta Pack and continued therapy) Has your patient already received 12 months of total treatment? ☐ Yes ☐ No
(if Lupaneta Pack and not received 12 months of treatment) How many months of treatment have been received?
(if Lupron Depot and continued therapy for uterine fibroids or leiomyomata) Has your patient already received 3 months of treatment? ☐ Yes ☐ No
(if Lupron 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 and Lupron Depot 11.25 mg) Is Lupron Depot being used as adjuvant therapy? ☐ Yes ☐ No
(if epithelial, NOT Lupron Depot 11.25 mg) Which of the following applies to your patient?

☐ patient has persistent disease
☐ patient has recurrent disease
☐ being used as adjuvant therapy
☐ other

(if epithelial and adjuvant) Which type of epithelial tumor does your patient have?

☐ serous or endometrioid
☐ clear cell or mucinous
☐ unknown or other

(if epithelial and adjuvant) Is the tumor low-grade or high-grade?

☐ low-grade
☐ high-grade

(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 patients? ☐ Yes ☐ No

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

(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:**_____

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