

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

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

PHYSICIAN INFORMATION			PATIENT INFORMATION				
* Physician Name:  Specialty: * DEA, NP		PI or TIN:	*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.*				
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	<b>:</b> :			
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: Firmagon: Lupron Depot: Leuprolide acetate depot: Lupron Depot-PED: Supprelin LA: Triptodur:	45mg (pedia 80mg 3.75mg 22.5mg 7.5mg 50mg kit 22.5mg	_	□ 11.25mg □ 15mg	☐ 22.5mg ☐ 30mg	☐ 30mg ☐ 45mg	☐ 45mg	
Dose: Frequency of administration:							
J-Code: ICD10:							
Patient weight: k	g or lk	os .					
Where will this medication be obtained?  Panther Rx (for Triptodur only)  Maxor National Pharmacy (for Fensolvi only)  Accredo Specialty Pharmacy**  Hospital Outpatient  Retail pharmacy  Other (please specify):				☐ Home Health / Home Infusion vendor ☐ Physician's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy			
**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							
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, infixion 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 inkinos site, physician's office, home) with assistance of a Speciatry Care Options Case Manager?    The requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient?    The requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient?    Diagnosis related to use (please specify):   Diagnosis related to the patient please (please):   Diagnosis related to the please (please):   Diagnosis re							
assistance of a Specialty Care Options Case Manager?		iate setting.					
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glapian tube cancer							
Glalipian tube cancer   gender-dysphorto/gender-incongruent persons (formerly known as gender identity disorder or GID))   gender reassignment surgery   infertitity   menstrual migraines   ovarian sex cord-stromal tumor (granulosa cell tumor, fibroma-thecoma, fibroma, thecoma, Sertoli-Leydig cell tumor)   polycystic ovarian syndrome (PCOS)   premenstrual disorders, including premenstrual syndrome and premenstrual dysphoric disorder   peripheral precocious puberty (GnRH-independent precocious puberty)   primary peritoneal cancer   salivery gland cancer   salivery gland cancer   salivery gland cancer   saliver glase specify;   (for requests of any other drug other than Supprelin LA) is this new start or continuation of therapy with this drug?   (if continued therapy and any drug other than Lupron Depot [leuprolide acetate depot] Supprelin LA) is there documentation of a beneficial response to this medication?   Ves   No (if Dreast) has your patient reached menopause?   Ves   No (if Dreast) has your patient reached menopause?   Ves   No (if Dreast) has your patient reached menopause?   Ves   No (if CPP and requesting any other drug than Supprelin LA, LH level NOT greater than or equal to 0.3mIU/mL) has the diagnosis been confirmed by a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.3mIU/mL) has the diagnosis been confirmed by a pubertal luteinizing hormone (LH) 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?   Ves   No (if CPP, requesting any other drug than Supprelin LA and male patient) Was the onset of secondary sexual characteristics earlier than 9 years of age?   Ves   No (if CPP and requesting Supprelin LA) Does the patient have a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.2 mIU/mi?   Ves   No (if CPP and requesting Supprelin LA) Has the patient have a pubertal luteinizing hormone (LH) response to a GnRH agonist stimulation test?   No (if CPP and req							
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(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 CPP and requesting Lupron Depot-Ped)		
The covered alternatives are Fensolvi or Triptodur. For the alternatives tried, please provide drug strength, date(s) tallong, and what the documented results were of taking this drug, including any intolerances or adverse reactions your experienced. For the alternatives NOT tried, please provide details why your patient can't try this alternative.		or how
Per the information provided above, which of the following is true for your patient in regard to the covered alternatives.  ☐ The patient tried one of the alternatives.  ☐ Other	<b>s</b> ?	
Has the patient has tried Fensolvi or Triptodur?	☐ 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 back)?	from com	
(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 vendocrinologist or a physician who specializes in the treatment of transgender patients/individuals?	with an ☐ 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 follitropin, urofollitropin or menotropins in a work premature luteinizing hormone (LH) surge?	oman with 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 Lupron Depot only) The covered alternatives are: Eligard and Firmagon (both may require prior authoral alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT provide details why your patient can't try that drug.	results we	ere of
(if prostate and Lupron Depot only) Per the information provided above, which of the following is true for your patient covered alternatives?  The patient has tried one of the alternatives.  The patient has not tried one of these alternatives.	in regard	to the

☐ Other or Unknown					
(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				
(if Lupron Depot [leuprolide acetate depot, if endometriosis) Has your patient previously used a gonadotropin-releasing agonist (for example, Lupron Depot, Synarel) or antagonist (for example, Orilissa for endometriosis)?	ng hormone Yes No				
(if Lupron Depot [leuprolide acetate depot, if endometriosis) The covered alternatives are: i. A contraceptive (e.g., combination oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena, Liletta]), or ii. An oral progesterone (e.g., norethindrone tablets), or iii. A depo-medroxyprogesterone injection. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.					
(if Lupron Depot [leuprolide acetate depot, if endometriosis) Per the information provided above, which of the followin patient in regard to the covered alternatives?  ☐ The patient tried at least ONE of the alternatives.  ☐ The patient cannot try one of these alternatives because of a contraindication to this drug.  ☐ Other	g is true for your				
(if Lupron Depot [leuprolide acetate depot, if Premenstrual Disorders) Does the patient have severe, refractory premesymptoms?	enstrual ☐ Yes ☐ No				
(if Premenstrual Disorders) Has the patient tried a combined oral contraceptive for this condition?	☐ Yes ☐ No				
(if no) Has the patient tried a selective serotonin reuptake inhibitor (SSRI) for this condition? Note: Examples citalopram, escitalopram, fluoxetine, fluoxamine, paroxetine, sertraline.	s of SSRIs include ☐ Yes ☐ No				
Additional Pertinent Information: (please include clinical reasons for drug, relevant lab values, etc. Where appliance include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used					
Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the insurer its designees may perform a routine audit and request the medical information necessary to verify the accordance information reported on this form.					
Prescriber Signature: Date:					
Save Time! Submit Online at: <a href="https://www.covermymeds.com/main/prior-authorization-forms/cigna/">www.covermymeds.com/main/prior-authorization-forms/cigna/</a> or via SureScri	pts 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.

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