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), Triptodur (triptorelin pamoate)

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				
Lupron Depot:	☐ 3.75mg	☐ 7.5mg	☐ 11.25mg	☐ 22.5mg	☐ 30mg	☐ 45mg
Leuprolide acetate depot:	☐ 22.5mg					
Lupron Depot-PED:	☐ 7.5mg	☐ 11.25mg	☐ 15mg	☐ 30mg	☐ 45mg	
Triptodur:	☐ 22.5mg					

Dose: Frequency of administration:

J-Code: ICD10:

Patient weight: kg or lbs

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
☐ Hospital Outpatient
☐ Physician's Office
☐ 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; persons undergoing gender reassignment (Female-To-Male [FTM] or Male-to-Female [MTF])
☐ infertility
☐ menstrual migraines
☐ ovarian cancer, including fallopian tube cancer and primary peritoneal cancer
☐ 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
☐ preservation of ovarian function/fertility in patients undergoing chemotherapy
☐ peripheral precocious puberty (GnRH-independent precocious puberty)
☐ primary peritoneal cancer
☐ prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy, or undergoing cancer treatment, or prior to bone marrow/stem cell transplantation (BMT/SCT)
☐ prostate cancer
☐ head and neck cancer – salivary gland tumors
☐ uterine leiomyomata (fibroids)
☐ uterine cancer
☐ other (please specify):

Clinical Information:

(if breast or ovarian cancer [including fallopian tube cancer and primary peritoneal cancer], prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy, or undergoing cancer treatment, or prior to bone marrow/stem cell transplantation [BMT/SCT, preservation of ovarian function/fertility in patients undergoing chemotherapy], uterine cancer, if requesting Lupron Depot) Is the requested medication being prescribed by or in consultation with an oncologist? ☐ Yes ☐ No

(if breast, if requesting any other drug than Lupron Depot) Does your patient have hormone receptor-positive breast cancer? ☐ Yes ☐ No

(if breast, if requesting any other drug than Lupron Depot) Has your patient reached menopause? ☐ 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 CPP and requesting Fensolvi, Lupron Depot-PED, Triptodur) Does the patient have a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.2 mIU/ml? ☐ Yes ☐ No

(if CPP and requesting Fensolvi, Lupron Depot-PED, Triptodur) Did the patient have a pubertal luteinizing hormone (LH) response to a GnRH agonist stimulation test? ☐ Yes ☐ No

(if CPP and requesting Lupron Depot-PED) Has the patient tried Fensolvi or Triptodur? ☐ Yes ☐ No

(if epithelial) if requesting any other drug than Lupron Depot) 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, if requesting any other drug than Lupron Depot) 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, if requesting any other drug than Lupron Depot) Will the requested medication be used as adjuvant therapy (to keep the cancer from coming back)? ☐ Yes ☐ No

(if fallopian tube or peritoneal, if requesting any other drug than Lupron Depot) Does your patient have persistent or recurrent disease? ☐ Yes ☐ No

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

(if infertility, if requesting Lupron Depot) Is the requested medication being used for females undergoing treatment of infertility? Please Note: Females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression. ☐ Yes ☐ No

(if infertility, if requesting Lupron Depot) Will the requested medication be used for ovulation suppression? ☐ Yes ☐ No

(if infertility, if requesting Lupron Depot) Will the requested medication be used to trigger ovulation? ☐ Yes ☐ No

(if infertility, if requesting any other drug than Lupron Depot) What infertility service is your patient undergoing? (e.g. IUI, IVF, GIFT, ZIFT, etc.)

(if infertility, if requesting any other drug than Lupron Depot) Will the requested medication be used in combination with follitropin, 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, if requesting any other drug than Lupron Depot) 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, if requesting any other drug than Lupron Depot) Does your patient have relapsed disease? ☐ Yes ☐ No

(if prostate, if requesting any other drug than Lupron Depot) Does your patient have advanced disease? ☐ Yes ☐ No

(if prostate and brand Lupron Depot only) Is the patient currently receiving the requested medication? ☐ Yes ☐ No

(if prostate and brand Lupron Depot only) Has the patient tried ONE of the following: a. Eligard [may require prior authorization]; or b. Firmagon [may require prior authorization]? ☐ Yes ☐ No

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

(if salivary gland, if requesting any other drug than Lupron Depot) Does your patient have recurrent disease? ☐ Yes ☐ No

(if salivary gland, if requesting any other drug than Lupron Depot) Does your patient have distant metastases? ☐ Yes ☐ No

(if Lupron Depot or leuprolide acetate depot, if endometriosis) Has the patient previously used a gonadotropin-releasing hormone agonist (for example, Lupron Depot) or antagonist (for example, Orilissa)? ☐ Yes ☐ No

(if no) Has the patient tried ONE of the following, unless contraindicated (A, B, or C): A) A contraceptive (for example, combination oral contraceptives, levonorgestrel-releasing intrauterine systems [for example, Mirena, Liletta]), OR B) An oral progesterone (for example, norethindrone tablets), OR C) A depo-medroxyprogesterone injection? ☐ Yes ☐ No

(if Lupron Depot [leuprolide acetate depot, if Premenstrual Disorders) Does the patient have severe, refractory premenstrual symptoms? ☐ 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 of SSRIs include citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline. ☐ Yes ☐ No

(if Lupron Depot [leuprolide acetate depot,] if Head and Neck Cancer – Salivary Gland Tumors) Does your patient have recurrent, unresectable, or metastatic disease? ☐ Yes ☐ No

(if Lupron Depot [leuprolide acetate depot], if Head and Neck Cancer – Salivary Gland Tumors) Is the patient's disease positive for androgen receptors? ☐ Yes ☐ No

Additional Pertinent Information:

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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