05/02/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Leuprolide Acetate (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Leuprolide Acetate (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Leuprolide Acetate

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of central precocious puberty (CPP)? Y N

   [If no, skip to question 11.]

2. Is therapy prescribed by or in consultation with an endocrinologist? Y N

   [If no, no further questions.]

3. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 9.]

4. Has an MRI or CT scan been performed to rule out lesions? Y N

   [If no, no further questions.]

5. Did the patient have onset of secondary sexual characteristics earlier than 8 years of age for a female patient and 9 years of age for a male patient? Y N

   [If no, no further questions.]

6. Has the diagnosis been confirmed by a response to a GnRH stimulation test, or if not available, other labs to support the diagnosis of CPP? If yes, document test results and date drawn: Y N

   [If no, no further questions.]

7. Is the patient's bone age advanced at least 1 year beyond the chronological age? If yes, document date of test, chronological age at the time of test, and bone age: Y N

   [If no, no further questions.]

8. Is the patient at least 1 year old? Y N

   [If yes, skip to question 10.]

   [If no, no further questions.]

9. Is the patient demonstrating a clinical response to treatment as demonstrated by any of the following? Please document all that apply: Y N

   Pubertal slowing or decline \ Suppression of FSH, LH, estradiol/testosterone levels \ Normalization of bone age

10. Does the patient meet one of the following? Y N

    Female patient who is less than 11 years of age \ Male patient who is less than 12 years of age

    [If no, no further questions.]

11. Does the patient have a diagnosis of prostate cancer? Y N

    [If no, no further questions.]

12. Is the patient at least 18 years old? Y N

[If no, no further questions.]

13. Is the requested drug prescribed by or in consultation with an oncologist or urologist? Y N

[If the answer to this question is no, then no further questions are required.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**