Prescriber Criteria Form

Lupron Endometriosis 2025 PA Fax 567-A v1 010125.docx
Lupron Depot 3.75 mg, 11.25 mg (leuprolide acetate for depot suspension)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Lupron Endometriosis.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of endometriosis? [If no, then skip to question 5.]	Yes ◯	No ◯
2	Is this a request for endometriosis retreatment? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient previously received a 6-month retreatment course of therapy? [If yes, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being used in combination with norethindrone acetate? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of uterine fibroids? [If no, then skip to question 10.]	Yes ◯	No ◯
6	Is the requested drug being used prior to surgery for uterine fibroids? [If yes, then skip to question 8.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10 grams per deciliter)? [If no, then no further questions.]	Yes ◯	No ◯

8	Is this a request for uterine fibroids retreatment? [If no, then no further questions.]	Yes ◯	No ◯
9	Has the patient previously received a 3-month retreatment course of therapy? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of ovarian, fallopian tube, or primary peritoneal cancer? [If yes, then no further questions.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of hormone receptor-positive breast cancer? [If yes, then no further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of salivary gland tumor? [If no, then no further questions.]	Yes ◯	No ◯
13	Is the requested drug being used for recurrent androgen receptor positive disease?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____