

# LUPRON (leuprolide)

## PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

<b>Today's Date:</b> _____				
<b>SECTION A - PATIENT INFORMATION</b>				
First Name:		Last Name:		Member ID:
Address:				
City:		State:		Zip:
Phone:		DOB:		Allergies:
Primary Insurance:		Policy #:		Group #:
Is the requested medication <b>NEW</b> <input type="checkbox"/> or a <b>CONTINUATION of THERAPY</b> <input type="checkbox"/> ? If so, start date: _____				
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>SECTION B - PHYSICIAN INFORMATION</b>				
First Name:		Last Name:		M.D./D.O.
Address:		City:		State: Zip:
Phone:		Fax:		NPI #: Specialty:
Office Contact Name / Fax Attention to:				
Medication to be Administered: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home				
Deliver Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other Address: _____				
<input type="checkbox"/> Patient's Home _____				
<b>SECTION C - MEDICAL INFORMATION</b>				
Medication:			Strength:	
Directions for use:				
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:	
<ul style="list-style-type: none"> <li>Is this a new prescription for the patient or a continuation of existing <b>leuprolide</b> therapy? If this is a continuation of therapy, how many months of <b>leuprolide</b> has the patient received?</li> <li>Did the patient experience any side effects or adverse reactions to leuprolide therapy? List adverse reactions and side effects: _____</li> <li>Has the patient had a bone density scan within the past year that was within normal limits? (Normal limits: T score &gt; -1)</li> <li>Is the patient taking norethindrone acetate concomitantly?</li> <li>If prescribed for endometriosis has the patient received therapy with norethindrone acetate, progesterone, or Danazol?</li> </ul>				
Explanation of why the preferred medication(s) would not meet your patient's needs:				
<b>Other Medications tried</b>				
<u>Medications</u>	<u>Strength</u>	<u>Directions</u>	<u>Dates of Therapy</u>	<u>Reason for failure / discontinuation</u>

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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