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:			*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	
Supprelin LA:	☐ 50mg kit					
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):

(for requests of any other drug other than Supprelin LA) Is this new start or continuation of therapy with this drug?
☐ new start ☐ continued therapy

(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? ☐ Yes ☐ No

Clinical Information:

(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 requesting any other drug than Supprelin LA) Has the diagnosis been confirmed by a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.3mIU/mL? ☐ Yes ☐ No

(if CPP, 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 luteinizing hormone (LH) response to a GnRH stimulation test? ☐ Yes ☐ 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? ☐ Yes ☐ No

(if CPP, requesting any other drug than Supprelin LA and female patient) Was the onset of secondary sexual characteristics earlier than 8 years of age? ☐ Yes ☐ 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/ml? ☐ Yes ☐ No

(if CPP and requesting Supprelin LA) Did the patient have a pubertal luteinizing hormone (LH) response to a GnRH agonist stimulation test? ☐ Yes ☐ No

(if CPP and requesting Supprelin LA) **Is the patient less than 2 years of age? ☐ Yes ☐ No

(if CPP and requesting Supprelin LA) Has the patient has 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 CPP and requesting Lupron Depot-Ped)

The covered alternatives are Fensolvi or Triptodur. For the alternatives tried, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try this alternative.

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

Has the patient has 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, 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 this medication prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients/individuals? ☐ 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 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) 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 Lupron Depot only) The covered alternatives are: Eligard and Firmagon (both may require prior authorization). 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 prostate and Lupron Depot only) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient has tried one of the alternatives.
☐ The patient has not tried one of these alternatives.
☐ Other or Unknown

(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 [leuprolide acetate depot, if endometriosis) Has your patient previously used a gonadotropin-releasing hormone agonist (for example, Lupron Depot, Synarel) or antagonist (for example, Orilissa for endometriosis)? ☐ 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 following is true for your 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

(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) Does your patient have androgen receptor-positive disease? ☐ Yes ☐ No

Additional Pertinent Information: *(please include clinical reasons for drug, relevant lab values, etc. Where applicable, please include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently.)*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts 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.

v051525

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005