



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Gonadotropin Releasing Hormone Analogs Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Height:	
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
<input type="checkbox"/> Firmagon	<input type="checkbox"/> Leuprolide acetate	<input type="checkbox"/> Lupaneta Pack	<input type="checkbox"/> Lupron Depot		<input type="checkbox"/> Lupron Depot-PED
<input type="checkbox"/> Eligard	<input type="checkbox"/> Orilissa	<input type="checkbox"/> Trelstar	<input type="checkbox"/> Triptodur		<input type="checkbox"/> Vantas
<input type="checkbox"/> Synarel	<input type="checkbox"/> Supprelin LA	<input type="checkbox"/> Zoladex	<input type="checkbox"/> Other, please specify:		
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No			ICD-10 Code:		Diagnosis:
What medication(s) have been tried and failed for diagnosis?		Are there any contraindications to formulary medications? (if yes, please specify):			<input type="checkbox"/> Yes <input type="checkbox"/> No
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
<input type="checkbox"/> Endometriosis					
Was there trial AND failure with at least ONE formulary hormonal cycle control agent OR medroxyprogesterone, in COMBO with NSAID?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have severe disease or recurrent symptoms?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Renewal Request ONLY:					
Treatment is for recurrence after initial course of therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Total duration of treatment for both initial AND recurrent symptoms will not be longer than 12 months?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Will add-back therapy with norethindrone be used concurrently?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Uterine Leiomyoma - Fibroids					
Is requested medication prescribed to improve		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there trial AND failure with iron	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		

anemia and/or reduce uterine size prior to planned surgical intervention?			to correct anemia?		
<input type="checkbox"/> Endometrial Thinning for Dysfunctional Uterine Bleeding					
Is requested medication prescribed to thin endometrium prior to planned endometrial ablation OR hysterectomy within next 4-8 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Central Precocious Puberty					
Was an MRI OR CT Scan performed to rule out brain lesions OR tumors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have onset of secondary sexual characteristics earlier than 8 years in females AND 9 years in males?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there response to GnRH stimulation test (or other labs to support CPP, such as LH level, estradiol AND testosterone level)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was bone age advanced 1 year beyond chronological age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY:					
Was there clinical response to treatment (for example, pubertal slowing or decline, height velocity, bone age, estradiol AND testosterone level)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Advanced Breast Cancer					
Is member at least 18 years of age AND premenopausal at time of diagnosis?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Advanced Ovarian Cancer					
Member cannot tolerate OR does not respond to cytotoxic regimens?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is drug requested being used for post-operative management?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Salivary Gland Cancer					
Does member have androgen receptor positive recurrent disease with distant metastases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there a performance status score of 0 – 3 by ECOG standards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Gender Dysphoria/Gender Incongruence in adolescents					
Was medication prescribed by Pediatric Endocrinologist that collaborated care with a Mental Health Provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member show persistent, well-documented diagnosis of gender non-conformity OR dysphoria that worsened with puberty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member exhibit signs of puberty with minimum Tanner stage 2?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has member made a fully informed decision AND given consent, AND parent/guardian consents to treatment OR member has been emancipated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are member's comorbid conditions reasonably controlled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was member educated on any contraindications AND side effects to therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was member informed of fertility preservation options prior to treatment?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY:					
Are there lab results to support response to treatment (for example, FSH, LH, weight, height, tanner stage, bone age)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Gender Dysphoria/Gender Incongruence in Adults					
Was requested medication prescribed by Endocrinologist that collaborated care with a Mental Health Provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member show persistent, well-documented diagnosis of gender dysphoria / incongruence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have capacity to make a fully informed decision and consents to treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are mental health concerns, if present, reasonably well controlled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was member informed of fertility preservation options prior to treatment?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY:					
Are there lab results to support response to treatment (for example, FSH, LH, weight, height, tanner stage, bone age)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

[Empty box for chart notes]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.