AmeriHealth Caritas
Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Lupron Depot – Adult

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for Lupron Depot (leuprolide acetate). Payment will be considered for patients under the following conditions:

1. Patient is 18 years of age or older; and
2. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and
3. Patient has a diagnosis of endometriosis for whom therapy with NSAIDs and at least one preferred three-month course of a continuous hormonal contraceptive has failed; or
4. Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or
5. Patient has a diagnosis of advanced prostate cancer.

Therapy will be limited as follows:

- **Endometriosis** – initial six-month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course.
- **Uterine leiomyomata** – three-month approval.
- **Advanced prostate cancer** – initial six-month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:

☐ Lupron Depot

Strength: Dosage instructions: Quantity: Days supply:

Setting to be administered:

☐ Member's home by home health ☐ Long-term care facility ☐ Other:

☐ **Endometriosis**. Payment will be considered for patients for whom therapy with NSAIDs and at least one preferred three-month course of a continuous hormonal contraceptive has failed.

NSAID trial: Drug name/dose:

Trial dates: Reason for failure:

Continuous hormonal contraceptive trial: Drug name/dose:

Trial dates: Reason for failure:

Renewal requests only:
Will member be prescribed concomitant norethindrone acetate 5mg daily? ☐ No ☐ Yes

☐ **Uterine leiomyomata.** Payment will be considered for patients with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively.

Iron trial: Drug name/dose:

Trial dates: Reason for failure:

Most recent hematocrit level: Date this level was obtained:

Most recent hemoglobin level: Date this level was obtained:

Is Lupron Depot to be used preoperatively? ☐ No ☐ Yes

☐ **Advanced prostate cancer**

Renewal requests only:

Most recent testosterone level (attach results):

Date this level was obtained:

☐ **Other diagnosis**

Possible drug interactions/conflicting drug therapies/other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.