AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Lupron Depot – Pediatric

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 - Pediatric. Payment will be considered for patients when the following is met:

1. Patient has a diagnosis of central precocious puberty (CPP); and
2. Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and
3. Patient is currently < 11 years of age for females or < 12 years of age for males; and
4. Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and
5. Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and
6. Baseline evaluations including the following have been conducted and/or evaluated:
   a. Height and weight measurements; and
   b. Sex steroid (testosterone or estradiol) levels have been obtained; and
   c. Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and
   d. Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and
   e. Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and
   f. Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and
7. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

When criteria for coverage are met, an initial authorization will be given for six months. Additional approvals will be granted at six-month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

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

Preferred:

☐ Lupron Depot-Ped

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

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Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males?
☐ No ☐ Yes: provide age of onset and description:

Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test?
☐ No ☐ Yes (attach results)

Documentation of advanced bone age (defined as ≥ two standard deviations above the gender/age related mean)?
☐ No ☐ Yes (attach results)

Baseline evaluations:

Height: Date obtained: Weight: Date obtained:

Sex steroid (testosterone/estradiol) levels obtained? ☐ No ☐ Yes (attach results)

Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor? ☐ No ☐ Yes (attach results)

Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors? ☐ No ☐ Yes (attach results)

Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor?
☐ No ☐ Yes (attach results)

Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia? ☐ No ☐ Yes (attach results)

Setting to be administered:

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

Age override consideration:

Documentation of medical necessity for continued treatment beyond the following ages:
females ≥ 11 years of age and males ≥ 12 years of age:

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.