Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Leuprolide Acetate
Lupron Depot (leuprolide acetate depot), Lupron Depot-PED (leuprolide acetate) Fensolvi (leuprolide acetate)
Firmagon (degarelix acetate)
Supprelin LA (histrelin acetate)
Triptodur (triptorelin pamoate)
Vantas (histrelin acetate)

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				
Leuprolide acetate	☐ 1mg/0.2ml					
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		
Supprelin LA:	☐ 50mg kit					
Triptodur:	☐ 22.5mg					
Vantas:	☐ 50mg kit					

Dose: Frequency of administration:
J-Code: ICD10:

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 (1640 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 (formerly known as gender identity disorder or GID))
☐ gender reassignment surgery
☐ hirsutism
☐ infertility
☐ menstrual migraines
☐ ovarian sex cord-stromal tumor (granulosa cell tumor, fibroma-thecoma, fibroma, thecoma, Sertoli-Leydig cell tumor)
☐ polycystic ovarian syndrome (PCOS)
☐ premenstrual syndrome (PMS)
☐ peripheral precocious puberty (gonadotropin-releasing hormone-independent precocious puberty)
☐ primary peritoneal cancer
☐ prostate cancer
☐ salivary gland cancer
☐ uterine fibroids or leiomyomata
☐ other (please specify):

Is this new start or continuation of therapy with this drug? ☐ new start ☐ continued therapy

(if continued therapy) Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No

(if Lupron Depot [leuprolide acetate depot] and continued therapy for uterine fibroids or leiomyomata) Has your patient already received 3 months of treatment? ☐ Yes ☐ No
(if Lupron Depot [leuprolide acetate depot] and not received 3 months) How many months of therapy has your patient received?

Clinical Information:

(if breast) Does your patient have hormone receptor-positive breast cancer? ☐ Yes ☐ No
(if breast) Has your patient reached menopause? ☐ Yes ☐ No

(if CPP) 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, 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 and male patient) Was the onset of secondary sexual characteristics earlier than 9 years of age? ☐ Yes ☐ No
(if CPP and female patient) Was the onset of secondary sexual characteristics earlier than 8 years of age? ☐ Yes ☐ No

(if epithelial) 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) Will the requested medication be used as adjuvant therapy (to keep the cancer from coming back)? ☐ Yes ☐ No

(if fallopian tube or peritoneal) 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? ☐ 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 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) Does your patient have relapsed disease? ☐ Yes ☐ No

(if prostate) Does your patient have advanced disease? ☐ Yes ☐ No

(if prostate and Firmagon or Vantas only) Is the requested medication being used as adjuvant therapy? ☐ Yes ☐ No

(if salivary gland) Does your patient have recurrent disease? ☐ Yes ☐ No

(if salivary gland) Does your patient have distant metastases? ☐ 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:**_____

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