# Eligard® (leuprolide acetate suspension for subcutaneous injection) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
**Phone:** 1-866-503-0857
**FAX:** 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | DOB: | |
| Address: | City: | State: | ZIP: |
| Home Phone: / Work Phone: | Cell Phone: | Email: | |
| Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms | Allergies: | | |

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #:

**Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ **Oncologist** ☐ **Endocrinologist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**

☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for:** ☐ **Eligard (leuprolide acetate) Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary ICD Code:** ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**

☐ **Gender dysphoria**
- ☐ Yes ☐ No ☐ N/A Is the requested medication prescribed by or in consultation with a pediatric endocrinologist that has collaborated care with a mental health care provider?
- ☐ Yes ☐ No Are the patient's comorbid conditions reasonably controlled?
- ☐ Yes ☐ No Has the patient been educated on any contraindications and side effects to therapy?
- ☐ Yes ☐ No Has the patient been informed of fertility preservation options?
- ☐ Yes ☐ No Is the requested drug being prescribed for pubertal suppression in an adolescent patient?
  - → Please indicate Tanner Stage of puberty the patient has reached:
    ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown
- ☐ Yes ☐ No Is the patient undergoing gender transition?
  - → ☐ Yes ☐ No Will the patient receive the requested drug concomitantly with gender affirming hormones?

☐ **Prostate cancer**

☐ **Recurrent salivary gland tumors**
- ☐ Yes ☐ No Is the tumor androgen receptor positive?
- ☐ Yes ☐ No Will the requested drug be used as a single agent?

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION** ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

**For Continuation Requests (clinical documentation required for all requests):**

☐ **Recurrent salivary gland tumors**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while on the current regimen?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while on the current regimen?

☐ **Prostate cancer**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while on the current regimen?

**H. ACKNOWLEDGEMENT**

**Request Completed By** ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.