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United Healthcare Community Plan

FLORIDA MEDICAID

Prior Authorization

Supprelin LA (histrelin acetate)

Maximum Length of Therapy = Date of Service

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number ___ - ___ - ____

Prescriber's Fax Number ___ - ___ - ____

Prescriber Specialty: _____

1. **Is this medication for precocious puberty?**
   ☐ Yes ☐ No
   If *YES*, specify ICD: _____

2. **Is the prescriber a pediatric endocrinologist?**
   ☐ Yes ☐ No

3. **Has the patient had a clinical course of either Lupron Depot-Ped or Synarel that has failed or was not tolerated (within the last six months)?**
   ☐ Yes ☐ No
   Note: Legible copies of progress notes describing these events are required, please attach.

Please submit measurement of blood concentration of total sex steroids, measurement of LH and FSH after stimulation with GnRH analog, and assessment of bone versus chronological age.

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-855-258-1593

02.15.2024