



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber's Phone Number

Grid for Prescriber's Phone Number

Prescriber's Fax Number

Grid for 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

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