UnitedHealthcare Community Plan

Pituitary Suppressive Agents, LHRH - Pennsylvania
Prior Authorization Request Form

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Central precocious puberty □ Endometriosis □ Gender dysphoria □ Management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women □ Preservation of ovarian function
□ Yes □ No	**Does the patient have a history of contraindication to the prescribed medication?**
□ Yes □ No	**If the requested medication is non-preferred, does the patient have history of therapeutic failure, contraindication, or intolerance of the preferred Pituitary Suppressive Agents, LHRH (luteinizing hormone-releasing hormone) approved or medically accepted for the patient's indication?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**If the request is for elagolix- or relugolix-containing agent, does the patient have a history of depression and/or suicidal thoughts or behaviors or is currently receiving treatment for depression and/or suicidal thoughts or behavior?**
□ Yes □ No □ Not applicable	**If yes to the above question, has the patient had a behavioral health assessment prior to use?**
CENTRAL PRECOCIOUS PUBERTY	
□ Yes □ No	**Is the requested medication prescribed by or in consultation with a pediatric endocrinologist?**
□ Yes □ No	**Was the onset of secondary sexual characteristics earlier than 8 years in females or 9 years in males?**
ENDOMETRIOSIS	
□ Yes □ No	**Does the patient have one of the following?** *(If yes, check which applies)* □ A diagnosis of endometriosis confirmed by laparoscopy □ A diagnosis of endometriosis supported by chart documentation of an adequate work-up that includes the clinical rationale for the diagnosis
□ Yes □ No	**Does the patient have history of any of the following?** *(If yes, check which applies & complete "Previous Medication Trials/Contraindications" section on first page)* □ Therapeutic failure, contraindication, or intolerance of non-steroidal anti-inflammatory drugs □ Therapeutic failure (based on a 3-month trial), contraindication, or intolerance of oral contraceptives
□ Yes □ No	**Is the requested medication prescribed in consultation with a gynecologist?**
GENDER DYSPHORIA - ADOLESCENT	
□ Yes □ No	**Is the requested medication prescribed by or in consultation with a pediatric endocrinologist, adolescent medicine specialist, or medical provider with experience and-or training in transgender medicine?**
□ Yes □ No	**Is the requested medication prescribed in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people?**
GENDER DYSPHORIA - ADULT	
□ Yes □ No	**Is the requested medication prescribed by or in consultation with an endocrinologist or medical provider with experience and-or training in transgender medicine?**
□ Yes □ No	**Is the requested medication prescribed in a manner consistent with current medical literature?**
MANAGEMENT OF HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS) IN PREMENOPAUSAL WOMEN – ORIAHNN / MYFEMBREE	
□ Yes □ No	**Does the patient have a history of therapeutic failure (based on a 3-month trial), contraindication, or intolerance of contraceptives?** (If yes, complete "Previous Medication Trials/Contraindications" section on first page)
PRESERVATION OF OVARIAN FUNCTION	
□ Yes □ No	**Is the patient receiving cancer treatment that is associated with premature ovarian failure [based on NCCN (National Comprehensive Cancer Network) guidelines or peer-reviewed medical literature]?**

Physician Signature: _____ **Date:** _____

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