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	☐ 45mg	
Supprelin LA:	☐ 50mg kit					
Triptodur:	☐ 22.5mg					
Vantas:	☐ 50mg kit					

Dose: Frequency of administration:

J-Code: ICD10:

Patient weight: kg or lbs

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 (1620 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 ☐ Physician's Office
☐ Hospital Outpatient ☐ 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
☐ infertility
☐ menstrual migraines
☐ ovarian sex cord-stromal tumor (granulosa cell tumor, fibroma-thecoma, fibroma, thecoma, Sertoli-Leydig cell tumor)
☐ polycystic ovarian syndrome (PCOS)
☐ premenstrual disorders, including premenstrual syndrome and premenstrual dysphoric disorder
☐ peripheral precocious puberty (gonadotropin-releasing hormone-independent precocious puberty)
☐ primary peritoneal cancer
☐ prostate cancer
☐ salivary gland cancer
☐ uterine fibroids or leiomyomata
☐ other (please specify):

(for requests of any other drug other than Supprelin LA) Is this new start or continuation of therapy with this drug?
☐ new start ☐ continued therapy

(if continued therapy and any drug other than Lupron Depot [leuprolide acetate depot] Supprelin LA) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

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 individuals? ☐ 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 follitropin, 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

(if Lupron Depot [leuprolide acetate depot, if endometriosis) Has your patient previously used a gonadotropin-releasing hormone agonist (for example, Lupron Depot, Synarel) or antagonist (for example, Orilissa for endometriosis)? ☐ Yes ☐ No

(if Lupron Depot [leuprolide acetate depot, if endometriosis) The covered alternatives are: i. A contraceptive (e.g., combination oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena, Liletta]), or ii. An oral progesterone (e.g., norethindrone tablets), or iii. A depo-medroxyprogesterone injection. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if Lupron Depot [leuprolide acetate depot, if endometriosis) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried at least ONE of the alternatives.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

(if Lupron Depot [leuprolide acetate depot, if Premenstrual Disorders) Does the patient have severe, refractory premenstrual symptoms? ☐ Yes ☐ No

(if Premenstrual Disorders) Has the patient tried a combined oral contraceptive for this condition? ☐ Yes ☐ No

(if no) Has the patient tried a selective serotonin reuptake inhibitor (SSRI) for this condition? Note: Examples of SSRIs include citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline. ☐ 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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