OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Lupron Depot® & Lupron Depot-Ped®
Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Central precocious puberty (idiopathic or neurogenic)
❑ Endometriosis
❑ Prostate cancer
❑ Uterine leiomyomata (fibroids)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For central precocious puberty (idiopathic or neurogenic), answer the following:

Did the onset of secondary sexual characteristics occur in the patient at less than 8 years of age if female or less than 9 years of age if male? ❑ **Yes** ❑ **No**
Has the patient had a pubertal response to a GnRH stimulation test? ❑ **Yes** ❑ **No**
Does the patient have a bone age that has advanced at least one year beyond the chronological age? ❑ **Yes** ❑ **No**
Does the patient have a peak luteinizing hormone (LH) level above pre-pubertal range? ❑ **Yes** ❑ **No**
Does the patient have a random LH level in the pubertal range? ❑ **Yes** ❑ **No**
Is the requested medication prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation of bone age monitoring (e.g., radiographic imaging)? ❑ **Yes** ❑ **No**
Does the patient have LH levels that have been suppressed to pre-pubertal levels? ❑ **Yes** ❑ **No**
Is the requested medication prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

For endometriosis, answer the following:

Has the patient had surgical ablation to prevent recurrence? ❑ **Yes** ❑ **No**
Has the patient had a trial and failure, contraindication, or intolerance to a non-steroidal anti-inflammatory drug (NSAID)? ❑ **Yes** ❑ **No**
Has the patient had a trial and failure, contraindication, or intolerance to an oral contraceptive? ❑ **Yes** ❑ **No**
Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Have the patient's symptoms recurred after one course of therapy? ❑ **Yes** ❑ **No**
Will Lupron Depot be used in combination with norethindrone 5mg daily, other "add-back" sex-hormones, or other bone-sparing agents? ❑ **Yes** ❑ **No**

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Prior Authorization Request Form (Page 2 of 2)

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For prostate cancer, answer the following:

Does the patient have advanced prostate cancer? ❑ **Yes** ❑ **No**

Does the patient have metastatic prostate cancer? ❑ **Yes** ❑ **No**

Is Lupron Depot being used for palliative care? ❑ **Yes** ❑ **No**

Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

Has the patient used Lupron Depot within the past 120 days? ❑ **Yes** ❑ **No**

For uterine leiomyomata (fibroids), answer the following:

Is Lupron Depot being used prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)? ❑ **Yes** ❑ **No**

Is Lupron Depot being used for the treatment of anemia? ❑ **Yes** ❑ **No**

Is the anemia caused by uterine leiomyomata (fibroids)? ❑ **Yes** ❑ **No**

Is Lupron Depot being used prior to surgery? ❑ **Yes** ❑ **No**

Is this request for continuation of prior therapy? ❑ **Yes** ❑ **No**

Quantity Limit:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading-dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.