

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

LEUPROLIDE DEPOT

Coverage Criteria / Required Medical Information

Prescriber must be Obstetrician/Gynecologist, Oncologist, Endocrinologist or Urologist (for diagnosis of prostate cancer).

For CPP, patient must be < 12 years old if female and < 13 years old if male.

For endometriosis only, patient must have completed a trial and failure of at least 2 of the following therapies: oral contraceptives, medroxyprogesterone, danazol.

For ovarian CA, patient has recurrent or stage II to stage IV ovarian cancer.

For prostate cancer, orchiectomy or estrogen therapy are unacceptable treatment options; used for initial treatment in advanced prostate cancer or when there is intermediate to high risk of recurrence; **or** used for adjuvant or neoadjuvant therapy.

Coverage Duration:

Fibroids - 3 months

Endometriosis - 6 months

Ovarian Cancer, Prostate Cancer, CPP - 12 months

Exclusion Criteria:

For endometriosis, fibroids, and ovarian cancer: pregnancy and breastfeeding.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



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Requested Drug			
LEUPROLIDE DEPOT	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No: <input type="checkbox"/>
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ Fax Form to 1-866-481-3704