Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Print Clear

Gonadotropin-Releasing Hormone Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Eligard (leuprolide)
☐ Firmagon (degarelix)
☐ Lupaneta Pack (leuprolide/norethindrone)
☐ Lupron (leuprolide)
☐ Supprelin LA (histrelin)
☐ Synarel (nafarelin)
☐ Trelstar (triptorelin)
☐ Triptodur (triptorelin)
☐ Vantas (histrelin)
☐ Zoladex (goserelin)

Dose, frequency and duration of requested drug

_____

Section I. Please complete for all requests.

1. Please indicate whether the request is for pharmacy or in-office billing. ☐ Pharmacy billing ☐ In-office billing
2. Indication for gonadotropin-releasing hormone (Check all that apply.).
   - ☐ Idiopathic or neurogenic central precocious puberty (CPP)
     Provide age of secondary sex characteristics onset. _____
     Is the member under the care of a pediatric endocrinologist?
     - ☐ Yes. I am a pediatric endocrinologist.
     - ☐ Yes. I am not a pediatric endocrinologist.
       Name of member's pediatric endocrinologist _____ Date of last visit _____
     - ☐ No. Please attach medical records of a consultation with a pediatric endocrinologist.
   - ☐ Endometriosis
     Provide date and outcomes for trials of both of the following. (Alternatively, provide clinical rationale why they are inappropriate.)
     Non-steroidal anti-inflammatory drugs (NSAIDs)
     - ☐ No. Please explain. _____
     - ☐ Yes. Date(s) _____
       Medication(s) _____
       Outcome(s) _____

Hormonal contraceptives
☐ No. Please explain. _____
☐ Yes. Date(s) _____
Medication(s) _____
Outcome(s) _____

☐ Endometrial thinning prior to ablation for abnormal uterine bleeding
Is surgery planned?
☐ Yes. Please provide anticipated date of surgery. _____
☐ No.

☐ Uterine leiomyomata (fibroids)
Is surgery planned?
☐ Yes. Please provide anticipated date of surgery. _____
☐ No. Please explain. _____

☐ Breast cancer
Does the member have advanced breast cancer? ☐ Yes ☐ No

☐ Prostate cancer

☐ Other. Please describe the medical necessity for the use of gonadotropin-releasing hormone, including previous trials and outcomes.

_____
_____
_____

Section II. Please also complete for Triptodur requests.

Has the member tried Lupron (leuprolide) and experienced an adverse reaction or inadequate response?
☐ Yes. Please provide date and outcome for trial.
Date(s) _____ Outcome(s) _____
☐ No. Please explain.
_____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____
_____
_____

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____

* *Required*

over

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____