Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Lupron Depot-Ped

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Request Type:

☐ Initial ☐ Continuation - Go to 8

Q2. Does the patient have a diagnosis of central precocious puberty (CPP)?

☐ Yes ☐ No

Q3. For female patients, are all of the following criteria are met:
A) Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging (e.g., computed tomography [CT] scan, magnetic resonance imaging [MRI]).
B) The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.
C) The assessment of bone age versus chronological age supports the diagnosis of CPP?

☐ Yes ☐ No ☐ NA

Q4. For male patients, are all of the following criteria are met:
A) Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging (e.g., CT scan, MRI).

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Patient Name:	**Prescriber Name:**

B) The diagnosis of CPP has been confirmed by a pubertal response to a GnRH agonist test or a pubertal level of a third generation LH assay.
C) The assessment of bone age versus chronological age supports the diagnosis of CPP.
D) The member was less than 9 years of age at the onset of secondary sexual characteristics?

☐ Yes ☐ No ☐ NA

Q5. Is the requested medication being used for pubertal hormonal suppression in an adolescent patient?

☐ Yes ☐ No

Q6. Does the patient meet all of the following criteria are met:
A) The member has a diagnosis of gender dysphoria.
B) The member is able to make an informed decision to engage in treatment.
C) The member has reached Tanner stage 2 of puberty or greater.
D) The member's comorbid conditions are reasonably controlled.
E) The member has been educated on any contraindications and side effects to therapy.
F) The member has been informed of fertility preservation options?

☐ Yes ☐ No ☐ NA

Q7. Is the requested medication being used for gender transition?

☐ Yes ☐ No

Q8. Does the member meet all of the following criteria:
A) The member has a diagnosis of gender dysphoria.
B) The member is able to make an informed decision to engage in treatment.
C) The member will receive the requested medication concomitantly with gender-affirming hormones.
D) The member's comorbid conditions are reasonably controlled.
E) The member has been educated on any contraindications and side effects to therapy.
F) The member has been informed of fertility preservation options?

☐ Yes ☐ No ☐ NA

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Patient Name:	**Prescriber Name:**

Q9. Is the requested medication being prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider for patients less than 18 years of age?

☐ Yes ☐ No

Q10. For continuation, what is the diagnosis?

☐ CCP (female) – go to 11
☐ CCP (male) – go to 13
☐ Pubertal hormonal suppression – go to 15
☐ Gender transition – go to 16

Q11. Is the female patient currently less than 12 years of age?

☐ Yes ☐ No

Q12. Is the patient currently receiving treatment and is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)?

☐ Yes ☐ No

Q13. Is the male patient currently less than 13 years of age?

☐ Yes ☐ No

Q14. Is the patient currently receiving treatment and is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)?

☐ Yes ☐ No

Q15. Does the patient meet all of the following criteria:
A) The patient has a diagnosis of gender dysphoria.
B) The patient is able to make an informed decision to engage in treatment.

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Patient Name:	**Prescriber Name:**

C) The patient has previously reached Tanner stage 2 of puberty or greater.
D) The patient's comorbid conditions are reasonably controlled.
E) The patient has been educated on any contraindications and side effects to therapy.
F) Before the start of therapy, the patient has been informed of fertility preservation options?

☐ Yes ☐ No

Q16. Additional Information:

Q17. Does the patient meet all of the following criteria:
A) The patient has a diagnosis of gender dysphoria.
B) The patient is able to make an informed decision to engage in treatment.
C) The patient will receive the requested medication concomitantly with gender-affirming hormones.
D) The patient's comorbid conditions are reasonably controlled.
E) The patient has been educated on any contraindications and side effects to therapy.
F) Before the start of therapy, the patient has been informed of fertility preservation options?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

v2025