Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Lupron® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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:

❑ Endometriosis
❑ Gender dysphoria (formerly known as gender identity disorder)
❑ Idiopathic or neurogenic central precocious puberty (CPP)
❑ Prostate cancer
❑ Uterine leiomyomata (fibroids)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Endometriosis:

Has the recipient had an inadequate response, adverse reaction or contraindication to a nonsteroidal anti-inflammatory drug (NSAID)? ❑ **Yes** ❑ **No**

Has the recipient had an inadequate response, adverse reaction or contraindication to a hormonal contraceptive? ❑ **Yes** ❑ **No**

Gender dysphoria (formerly known as gender identity disorder):

Is the requested medication being prescribed for the suppression of puberty? ❑ **Yes** ❑ **No**

Does the provider indicate a demonstrable knowledge of what gonadotropins medically can and cannot do and their social benefits and risks? ❑ **Yes** ❑ **No**

Does the recipient have a documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin? ❑ **Yes** ❑ **No**

Has the recipient had a period of psychotherapy for a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)? ❑ **Yes** ❑ **No**

Select if the recipient meets the definition of gender dysphoria characterized by the following:

❑ A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
❑ Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
❑ The disturbance is not concurrent with a physical intersex condition
❑ The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
❑ The transsexual identity has been present persistently for at least two years
❑ The disorder is not a symptom of another mental disorder or a chromosomal abnormality

Idiopathic or neurogenic central precocious puberty (CPP):

Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

Is there an onset of secondary sex characteristics before age eight years (females) or nine years (males)? ❑ **Yes** ❑ **No**

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Uterine leiomyomata (fibroids):

Is the recipient symptomatic? ❑ **Yes** ❑ **No**

Will documentation of the anticipated surgery date (or notation that surgery is planned once the fibroids shrink) or clinical rational why surgical intervention is not required be submitted?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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