

MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-888-865-6531

OR Mail request to: Pharmacy Services PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Supprelin LA (histrelin acetate) Maximum Length of Therapy = Date of Service

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY)																													
Recipient's Full Name																													
	Pro	escr	iber'	s Fu	II Na	me			1		1				1	1			1		1	1			1	ı			
Pres	cribe	er's	NPI			ı				1						•		•			•		•						
Pres	cribe														Pres	rescriber's Fax Number													
			-				•														•				-				
Dro	Prescriber Specialty:																												
•																													
1	1. Is this medication for precocious puberty?																												
	☐ Yes ☐ No																												
If Y	If Yes, specify ICD:																												
2	2. Is the prescriber a pediatric endocrinologist?																												
3	. н	las 1	he p	atie	nt h	ad a	clir	nical	coı	ırse	of e	eithe	r Lu	proi	ı De	pot-	Ped.	, Trip	otod	ur, c	or in	trana	asal	Syn	arel	tha	t has	fail	led
	3. Has the patient had a clinical course of either Lupron Depot-Ped, Triptodur, or intranasal Synarel that has failed or was not tolerated (within the last six months)?																												
	☐ Yes ☐ No																												
	Note: Legible copies of progress notes describing these events are required, please attach.																												
Please submit measurement of blood concentration of total sex steroids, measurement of LH and FSH after stimulation with GnRH analog, and assessment of bone versus chronological age.																													
stır	nula	tion	Wit	n Gr	iRH	ana	log,	and	ass	essi	men	it of	bon	e ve	rsus	chr	ono	logi	cal a	ige.									
Pre	Prescriber's Signature:															Date:													
REC	REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent																												
copies of related labs. The provider must retain copies of all documentation for five years.																													

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