MEDICATION PRIOR AUTHORIZATION REQUEST FORM

**FAX this completed form to 1-888-865-6531**

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

Call 1-833-705-1351 to request a 72-hour supply of medication.

Envolve Pharmacy Solutions 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.

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

# Supprelin LA (histrelin acetate)

**Maximum Length of Therapy = Date of Service**

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

envolve Pharmacy Solutions

**Recipient's Medicaid ID#**

**Date of Birth (MM/DD/YYYY)**

**Recipient's Full Name**

**Prescriber's Full Name**

**Prescriber's NPI**

**Prescriber Phone Number**

**Prescriber Fax Number**

**Prescriber Specialty:** _____

**Is this medication for precocious puberty?**

☐Yes ☐No

**If Yes, specify ICD:** _____

**Is the prescriber a pediatric endocrinologist?**

☐Yes ☐No

**Has the patient had a clinical course of either Lupron Depot-Ped or 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.**

Prescriber's Signature: _____ Date: _____

**REQUIRED FOR REVIEW:** Copies of medical records (i.e., 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.**