Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Fensolvi, Lupron Depot, Lupron Depot Ped, Lupaneta Pack, Supprelin LA, Triptodur, Vantas or Zoladex

Version20 Effective: 06/28/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug request	
Please select the drug you are requesting (select **one**):	
☐ Fensolvi (proceed to Q4)	☐ Lupron Depot (proceed to Q5)

Continued on next page

☐ Lupron Depot Ped (proceed to Q4)	☐ Lupaneta Pack (proceed to Q5)
☐ Supprelin LA (proceed to Q4)	☐Triptodur (proceed to Q4)
☐ Vantas (proceed to Q4)	☐ Zoladex (proceed to Q4)

☐ Other (please specify):

4. Peripheral Precocious Puberty

Is the requested medication being used for Peripheral Precocious Puberty? (Proceed to Q6)
☐Yes

☐ No

5. Is the requested medication being used for any of the following conditions?

Please choose any of the following that apply: (Proceed to Q6)

☐ Hirsutism

☐ Menstrual migraine

☐ Premenstrual Syndrome (PMS)

☐ Polycystic ovarian syndrome (PCOS)

☐ None of the above

6. Requested dosing

Please document the requested dosing:

7. Member's weight

Please specify the member's weight in kg:

8. Diagnosis the medication is being used to treat

What is the diagnosis the requested medication is being used to treat: (select one)

- ☐ Abnormal uterine bleeding (if the selected drug is Lupron Depot, proceed to Q14)
- ☐ Abnormal uterine bleeding (if the selected drug is Zoladex, proceed to Q9, then Q12)
- ☐ Breast cancer (if the selected drug is Lupron Depot, proceed to Q14)
- ☐ Breast cancer (if the selected drug is Zoladex, proceed to Q9, then Q13)
- ☐ Central Precocious Puberty (Proceed to Q9)
- ☐ Endometriosis (if the selected drug is Lupron Depot, proceed to Q10)
- ☐ Endometriosis (if the selected drug is Zoladex, proceed to Q9, then Q14)
- ☐ Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-to-Male or Male-to-Female) (proceed to Q9)
- ☐ Head and neck cancer – salivary gland tumors (proceed to Q9, then Q11)
- ☐ Ovarian cancer (proceed to Q9)
- ☐ Preservation of ovarian function/fertility in members undergoing chemotherapy (proceed to Q9)
- ☐ Prophylaxis or treatment of uterine bleeding in members with Hematologic Malignancy or undergoing cancer treatment, or prior to Bone Marrow/Stem Cell Transplantation (BMT/SCT) (proceed to Q9)
- ☐ Prostate cancer (proceed to Q9)
- ☐ Uterine Leiomyomata (fibroids) (proceed to Q14)
- ☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attach applicable chart notes in faxed request.

9. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Endocrinologist	☐ Obstetrician-gynecologist
☐ Oncologist	☐ Transgender medicine
☐ Women's health	

☐ Other (please indicate what specialty below):

10. Endometriosis diagnosis

If the selected diagnosis is Endometriosis, please select all of the following that the member has tried (proceed to Q14)

☐ A contraceptive (e.g. combination of oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena®, Liletta®])

☐ An oral progesterone (e.g., norethindrone tablets)

☐ A depo-medroxyprogesterone injection, unless contraindicated

☐ Previous trial of gonadotropin-releasing hormone [GnRH] agonist (e.g., Lupron-Depot)

☐ Previous trial of gonadotropin-releasing hormone antagonist (e.g Orilissa)

11. Head and neck cancer diagnosis

If the selected diagnosis is Head and Neck Cancer- Salivary Gland Tumors, please select ALL of the following that apply: (proceed to Q14)

☐ Member has advanced salivary gland tumors with distant metastases

☐ Member has androgen receptor (AR)-positive disease

12. Abnormal uterine bleeding diagnosis

If the selected diagnosis is abnormal uterine bleeding, is the requested medication being used as an endometrial-thinning agent prior to endometrial ablation? (proceed to Q14)

☐ Yes

☐ No

13. Breast cancer diagnosis

If the selected diagnosis is breast cancer, is the requested medication being used in premenopausal or perimenopause women? (proceed to Q14)

☐ Yes
☐ No

14. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial

☐ Continuation (proceed to Q15)

15. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.