Prescriber Criteria Form Leuprolide Inj 2026 PA Fax 4629-A v2 010126.docx Leuprolide acetate injection solution Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Leuprolide acetate injection solution.

Drug Name: Leuprolide acetate injection solution

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of prostate cancer? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of recurrent androgen receptor positive salivary gland tumor? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for a child with growth failure and advancing puberty? [If no, then skip to question 5.]	Yes	No
4	Will the requested drug be used in combination with growth hormone (GH)? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of central precocious puberty (CPP)? [If no, then no further questions.]	Yes	No
6	Is the patient currently receiving the prescribed medication? [If yes, then skip to question 12.]	Yes	No
7	Has the diagnosis of central precocious puberty (CPP) 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? [If no, then no further questions.]	Yes	No

8	Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty (CPP)? [If no, then no further questions.]	Yes	No
9	Is the patient female? [If no, then skip to question 11.]	Yes	No
10	Did the onset of secondary sexual characteristics occur prior to eight years of age? [If yes, then skip to question 12.] [If no, then no further questions.]	Yes	No
11	Did the onset of secondary sexual characteristics occur prior to nine years of age? [If no, then no further questions.]	Yes	No
12	Is the patient less than 12 years of age if female or less than 13 years of age if male?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____