Prescriber Criteria Form Synarel 2026 PA Fax 5802-A v2 010126.docx Synarel (nafarelin acetate) 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 Synarel (nafarelin acetate).

Drug Name: Synarel (nafarelin acetate)

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 central precocious puberty (CPP)? [If no, then skip to question 9.]	Yes	No
2	Is the patient currently receiving the prescribed medication? [If yes, then skip to question 8.]	Yes	No
3	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
4	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
5	Is the patient female? [If no, then skip to question 7.]	Yes	No
6	Did the onset of secondary sexual characteristics occur prior to eight years of age? [If yes, then skip to question 8.] [If no, then no further questions.]	Yes	No
7	Did the onset of secondary sexual characteristics occur prior to nine years of age? [If no, then no further questions.]	Yes	No

8	Is the patient less than 12 years of age if female or less than 13 years of age if male? [No further questions.]	Yes	No
9	Is the requested drug being prescribed for the management of endometriosis, including pain relief and reduction of endometriotic lesions? [If no, then no further questions.]	Yes	No
10	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes	No
11	Has the patient already received greater than or equal to 6 months of treatment with the requested drug?	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:**_____