Updated: 03/2023
DMMA Approved: 04/2023

Request for Prior Authorization for Supprelin LA (histrelin acetate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Supprelin LA (histrelin acetate) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Supprelin LA (histrelin acetate) Prior Authorization Criteria:

*** Note: please reference the Highmark Health Options Gender Transition Services (MP-033-MD-DE) policy for all gender dysphoria requests.**

Coverage may be provided with a diagnosis of central precocious puberty (CPP) when all of the following criteria is met:

- Current age ≤ 11 for females or ≤ 12 for males
- Must meet all of the following diagnostic criteria:
  - Baseline LH and FSH in pubertal range
  - A pubertal response to GnRH stimulation test
  - Advanced bone age (≥2 standard deviations above the gender/age related mean or bone age at least 1 year greater than chronological age)
  - Neuro-imaging (CT or MRI) to rule out intracranial tumor
  - Adrenal steroid levels to exclude congenital adrenal hyperplasia
  - If a male, human chorionic gonadotropin level to rule out a chorionic gonadotropin secreting tumor
- Onset of secondary sexual characteristics occurred at age < 8 years of age for females and <9 years of age for males
- Documentation showing the member has tried and failed or had an intolerance or contraindication to leuprolide acetate (Lupron Depot)*
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria:**
  - Current age ≤ 11 years old for females or ≤ 12 years old for males
  - Documentation of a physical exam in the past year with evaluation of growth and pubertal development
- **Reauthorization Duration of approval:** 12 months

*Lupron Depot may require prior authorization

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. HEALTH OPTIONS

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Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. HEALTH OPTIONS

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SUPPRELIN LA (HISTRELIN ACETATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Central precocious puberty (CPP), ICD-10: _____

- What age was the onset of secondary sexual characteristics? _____
- Is baseline LH and FSH in pubertal range? ☐ Yes ☐ No
- Was there a pubertal response to a GnRH stimulation test? ☐ Yes ☐ No
- Does the member have advanced bone age? ☐ Yes ☐ No
- Has neuro-imaging been done? ☐ Yes ☐ No
- Have adrenal steroid levels been checked? ☐ Yes ☐ No
- If male, has human chorionic gonadotropin level been checked? ☐ Yes ☐ No

☐ Other: _____, ICD-10: _____

Has Lupron Depot been tried? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Did member have a physical exam in the past year with evaluation of growth and pubertal development? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature Date

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