

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 \leq 11 for females or \leq 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 (\geq 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 \leq 11 years old for females or \leq 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.

**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) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a 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



Updated: 03/2019
DMMA Approved: 04/2019