Updated: 04/2025
DMMA Approved: 04/2025

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

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

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

Zoladex (goserelin acetate) Prior Authorization Criteria:

For all requests for Zoladex (goserelin acetate) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Member does not have any known contraindications to therapy
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage may be provided with a diagnosis of prostate cancer

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria:**
  - Documentation of continued benefit from therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of advanced breast cancer

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria:**
  - Documentation of continued benefit from therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of **endometriosis** and the following criteria is met:

- Must meet one of the following diagnostic criteria:
  - Confirmed by laparoscopy
  - Complete an evaluation to exclude other causes of pelvic pain
- Must be prescribed by or in consultation with a gynecologist
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to ALL of the following:
  - Estrogen-progestin contraceptives, progestins, or danazol
  - NSAIDs
  - Leuprolide acetate*
- **Maximum Duration of Approval:** 6 months

Coverage may be provided with a diagnosis of **dysfunctional uterine bleeding** and the following criteria is met:

- Must be used as an endometrial-thinning agent prior to endometrial ablation (surgery)
- Must be prescribed by or in consultation with a gynecologist
- Dose does not exceed 3.6 mg per month
- **Initial Duration of Approval:** 2 months (1 treatment course)
- **Reauthorization criteria:**
  - Documentation of the reason for delay in surgery
- **Reauthorization Duration of Approval:** 2 months (one additional treatment course; maximum of 2 courses total)

*Leuprolide acetate 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.

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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ZOLADEX (GOSERELIN 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 am to 7 pm

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:	ICD Code:

Endometriosis:

Has the diagnosis been confirmed by laparoscopy or has a complete evaluation to exclude other causes of pelvic pain been performed? ☐ Yes ☐ No (must provide chart documentation of an evaluation to exclude other diagnoses)

Has the member tried and failed any of the following? Please list below: ☐ NSAIDs ☐ Contraceptives, progestins, or danazol ☐ Leuprolide acetate

Dysfunctional uterine bleeding:

Is this being used prior to endometrial ablation? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Prostate and breast cancer: Does the member continue to benefit from therapy? ☐ Yes ☐ No

Endometriosis: Provide the reason for retreatment:

Dysfunctional uterine bleeding: Provide the reason for delay in surgery:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date