Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Gonadotropin-Releasing Hormone Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Eligard (leuprolide)
☐ Fensolvi (leuprolide)
☐ Firmagon (degarelix)
☐ Lupaneta Pack (leuprolide/norethindrone)
☐ Lupron (leuprolide)
☐ Myfembree (relugolix/estradiol/norethindrone)
☐ Orgovyx (relugolix)
☐ Oriahnn (elagolix/estradiol/norethindrone)
☐ Orilissa (elagolix)
☐ Supprelin LA (histrelin)
☐ Synarel (nafarelin)
☐ Trelstar (triptorelin)
☐ Triptodur (triptorelin)
☐ Vantas (histrelin)
☐ Zoladex (goserelin)

Dose, frequency, and duration of medication requested _____

Indication (Check all that apply.)

☐ Advanced breast cancer
☐ Advanced prostate cancer
☐ Endometrial thinning prior to ablation for abnormal uterine bleeding
☐ Castration-sensitive metastatic prostate cancer
☐ Endometriosis
☐ Idiopathic or neurogenic central precocious puberty (CPP)
☐ Uterine leiomyomata (fibroids)
☐ Other _____

Please indicate whether the request is for pharmacy or in-office billing. ☐ Pharmacy billing ☐ In-office billing

Section I. Please complete for requests for idiopathic or neurogenic CPP.

1. Provide age of secondary sex characteristics onset. _____
2. Is the member under the care of a pediatric endocrinologist?
   ☐ Yes. Name of member's pediatric endocrinologist _____ Date of last visit _____
   ☐ No. Please attach medical records of a consultation with a pediatric endocrinologist.

3. For Fensolvi and Triptodur, has the member tried Lupron and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain. _____

Section II. Please complete for requests for endometriosis.

1. Has the member tried non-steroidal anti-inflammatory drugs (NSAIDs) and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) _____ Date(s) _____ Outcome(s) _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) _____ Date(s) _____ Outcome(s) _____
   ☐ No. Please explain if there is a contraindication to this trial. _____
3. For Orilissa, has the member tried Lupron and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain if there is a contraindication to this trial. _____

Section III. Please complete for requests for endometrial thinning prior to ablation for abnormal uterine bleeding and uterine leiomyomata (fibroids).

1. Is surgery planned?
   ☐ Yes. Please provide anticipated date of surgery. _____
   ☐ No. Please explain. _____
2. Has the member tried hormonal contraceptives and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain. _____
3. For Myfembree and Oriahnn, has the member tried Lupron and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain. _____
4. For Myfembree, has the member tried Oriahnn and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain. _____
5. For Myfembree and Oriahnn, has the member previously received therapy with the requested agent?
   ☐ Yes. Please provide previous duration of therapy. _____ ☐ No.

Section IV. Please complete for requests for castration-sensitive metastatic prostate cancer.

1. Please indicate prescriber specialty. ☐ Oncology ☐ Urology ☐ Other _____
2. Has the member tried Vantas or Zoladex and experienced an adverse reaction or inadequate response?
   ☐ Yes. Provide drug names, dates, and outcomes for trials below.
   Drug name(s) _____ Date(s) _____ Outcome(s) _____

over

☐ No. Please explain. _____

_____

3. Has the member tried Firmagon and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please provide date and outcome for trial.
   Date(s) _____ Outcome(s) _____
   ☐ No. Please explain. _____

Section V. Please complete for all other diagnoses, excluding advanced breast cancer and advanced prostate cancer.

Please describe the medical necessity for the use of gonadotropin-releasing hormone, including previous trials and outcomes.

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Section VI. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____