Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions (including frequency):_____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Gonadotropin Releasing Hormones agonists and antagonists – Medical Necessity Request

****Complete pages 1, 2, and 3 for New/Initial Requests****

Contraindication Information:

- Is the member pregnant or planning to become pregnant while on therapy? **Yes or No**
- Is the member breast-feeding? **Yes or No**
- Does the member have Osteoporosis? **Yes** or **No**
- Does the member have Severe Hepatic impairment? **Yes** or **No**
- Will the member be receiving strong anion transporting polypeptide (OATP) 1B1 inhibitors (e.g., cyclosporine and gemfibrozil) concomitantly? **Yes** or **No**

Diagnosis Information (please indicate diagnosis and answer related questions):

□ **Prostate Cancer**

a) Is the disease metastatic (including N1 metastases to lymph nodes and M1 distant metastases)? **Yes or No**
b) Is the disease advanced or locally advanced? **Yes or No**
c) Is the disease localized? **Yes or No**
   a. If Yes, will the member be receiving radiation therapy?
      □ **Yes**
         i. What is the patient's risk? □ Intermediate □ High □ Very High
         ii. How will the drug be given in relation to the radiation therapy? □ Neoadjuvant □ Concomitant □ Adjuvant
      □ **No**
         i. Please indicate if the member has any of the following (please indicate all that apply):
            □ Disease recurrence after radiation therapy or brachytherapy
            □ Very high risk disease and is not a candidate for definitive therapy
            □ Progressive castration-naïve disease

d) Is the request for palliative therapy for men? **Yes or No**
   a. If Yes, please indicate if the member has any of the following (please indicate all that apply):
      □ Life expectancy ≤5 years
         a. If yes, please indicate if the member has:
            □ High Risk □ Very High Risk □ Regional □ Metastatic Disease
      □ Disease progression during observation with symptom development
   □ Changes in Prostate-specific antigen (PSA) level suggesting symptom development is likely

e) Please provide any additional information about the member's disease state:
   _____
   _____

□ **Uterine Fibroids (Leiomyomata)**

a) Does the member have anemia due to the fibroids? **Yes or No**
b) Will the member be undergoing surgery for the fibroids? **Yes or No**
c) Has the member previously had surgery for the fibroids? **Yes or No**
d) Has the member tried iron therapy and if so, for how long? _____
e) Did the member respond to iron therapy? **Yes or No**
   a. If no, please let us know the specific reason for failure**:** _____
   _____
f) Will the member be receiving iron with the Lupron? **Yes or No**
   a. If no, please let us know why not? _____
g) What is the size of the fibroid(s)? _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions (including frequency):_____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Precocious Puberty**

a) Is the precocious puberty either true or central? **Yes or No**
b) Has tumor been ruled out by appropriate diagnostic procedure? **Yes or No**
c) Does the member have an onset of secondary sexual characteristics that occurred at or before age 9? **Yes or No**

d) Does the member **only** have pubic hair and/or axillary hair and/or axillary odor as the only signs of sexual development? **Yes or No**
   i. If Yes, does the member have one of the following (please indicate which):
      □ Diagnosis of Premature Adrenarche has been excluded
      □ Had a pubertal response to a GnRH stimulation test
      □ Bone age advanced one year beyond the chronological age
      □ Diagnosis has been confirmed by an endocrinologist
      □ None of the above

□ **Ovarian Cancer**

a) Please indicate which applies: Is the member: □ Pre-operative □ Post-operative
b) Does the member have any of the following (please indicate all that apply):
   □ Grade 1 endometrioid epithelial carcinoma or Low-grade serous carcinoma
      a) Does the member have Stage IC, Stage II-IV disease? Yes or No
   □ Borderline epithelial tumors with invasive implants
   □ Recurrence of epithelial ovarian/fallopian tube/primary peritoneal disease
      a) Is the member resistant or intolerant to cytotoxic or targeted therapy or has the member failed preferred cytotoxic or targeted therapy? **Yes or No**
   □ Recurrence of malignant sex cord-stromal tumor (i.e. granulosa cell tumor)
   □ None of the above

d) Which therapies has the member previously failed, not tolerated, or has a contraindication to?
_____
_____

□ **Ovarian Protection during Chemotherapy**

a) Will the medication be administered while receiving chemotherapy treatment? **Yes or No**
b) Is the member premenopausal? **Yes or No**

□ **Breast Cancer**

a) Is it recurrent? **Yes or No**
b) Is it metastatic? **Yes or No**
c) What is the member's menopausal status? □ Premenopausal □ Perimenopausal □ Postmenopausal
d) Does the member have hormone receptor positive breast cancer? **Yes or No**
e) What therapies will this medication be given in combination with? _____
_____

□ **Dysfunctional (Abnormal) Uterine Bleeding**

a) Will the member be undergoing surgery (endometrial ablation)? **Yes or No**
b) What is the abnormal bleeding associated with? (If it is due to one of the listed diagnoses, please also choose that diagnosis and answer related questions). _____
c) How many depot injections will the member receive before surgery (endometrial ablation)? _____
d) Once depot injections are given, after how many weeks will surgery be performed ? _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions (including frequency):_____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Menorrhagia (Heavy bleeding)/ Excessive or frequent menstruation (ICD-9 code 626.2)**

a) What is the heavy bleeding associated with? (If it is due to one of the listed diagnoses, please also choose that diagnosis and answer related questions). _____

_____

□ **Suppression of Menstruation or Ovarian Protection during Transplant**

a) Will the member be undergoing Bone Marrow Transplant? **Yes or No**
b) Is the member premenopausal? **Yes or No**

□ **Endometriosis**

a) How many total weeks of therapy has the member previously received of the requested drug? _____
b) Does the member have pain? **Yes** or **No**
   - If **Yes,** what is the severity of the pain? □ Mild □ Moderate □ Severe
c) Does the member have Dyspareunia? **Yes** or **No**
d) Does the member have moderate hepatic impairment (Child-Pugh Class B)? **Yes** or **No**

□ **Gender Identity Disorder/Gender Incongruence or Gender Dysphoria**

For Adolescent members:

a) Is the member 10-19 years of age? **Yes or No**
b) Has the member undergone surgery for gender reassignment (e.g. gonadectomy)? **Yes or No**
c) Does the member fulfill the DSM V criteria for gender dysphoria? **Yes or No**
d) Has the member experienced puberty to at least Tanner stage 2? **Yes or No**
e) Has the member had (early) pubertal changes that have resulted in an increase of their gender dysphoria? **Yes or No**
f) Does the member suffer from a psychiatric comorbidity that interferes with the diagnostic work-up or treatment? **Yes or No**
g) Will the member be psychological and social support during treatment? **Yes or No**
h) Does the member demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment? **Yes or No**

For Adult members:

a) Is the member 20 years of age or older? **Yes or No**
b) Is the member receiving gender-affirming hormone therapy (e.g., testosterone, estrogen) together with GnRH **Yes or No**
c) Has the member undergone surgery for gender reassignment (e.g. gonadectomy)? **Yes or No**
d) Does the member fulfill the DSM V criteria for gender dysphoria? **Yes or No**
e) Does the member have the ability to make a fully informed decision and to consent for treatment? **Yes or No**
f) Are coexistent mental health conditions reasonably well controlled? **Yes or No**

□ **Other**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions (including frequency):_____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete pages 4 and 5 ONLY for subsequent/renewal requests****

Diagnosis Information (please indicate diagnosis and answer related questions):

□ **Prostate Cancer**

a) Is the disease metastatic (including N1 metastases to lymph nodes and M1 distant metastases)? **Yes or No**
b) Is the disease advanced or locally advanced? **Yes or No**
c) Is the disease localized? **Yes or No**
    a. If Yes, will the member be receiving radiation therapy?
        □ **Yes**
            i. What is the patient's risk? □ Intermediate □ High □ Very High
            ii. How will the drug be given in relation to the radiation therapy? □ Neoadjuvant □ Concomitant □ Adjuvant
        □ **No**
            i. Please indicate if the member has any of the following (please indicate all that apply):
                □ Disease recurrence after radiation therapy or brachytherapy
                □ Very high risk disease and is not a candidate for definitive therapy
                □ Progressive castration-naïve disease after radiation therapy, brachytherapy, or radical prostatectomy

a) Is there any other information the physician's office can share about the member's disease state?

_____

□ **Endometriosis**

a) Have symptoms recurred after 6 months of therapy? **Yes or No**
b) Will the member be concomitantly receiving Norethindrone? **Yes or No**
c) How many total weeks of therapy has the member previously received of the requested drug?
_____
d) Does the member have pain? **Yes** or **No**
- If **Yes,** what is the severity of the pain? □ Mild □ Moderate □ Severe

e) Does the member have Dyspareunia? **Yes** or **No**
f) Does the member have moderate hepatic impairment (Child-Pugh Class B)? **Yes** or **No**

□ **Uterine Fibroids (Leiomyomata)**

a) Has the member undergone Endometrial Ablation? **Yes or No**

□ **Precocious Puberty**

□ **Ovarian Cancer**

□ **Ovarian Protection during Chemotherapy**

a) Will the member be receiving chemotherapy chemotherapy treatment? **Yes or No**
b) Is the member premenopausal? **Yes or No**

□ **Breast Cancer**

a) Is the breast cancer recurrent? **Yes or No**
b) Is the breast cancer metastatic? **Yes or No**
c) What is the member's menopausal status? □ Premenopausal □ Postmenopausal □ Perimenopausal
d) Does the member have hormone receptor positive breast cancer? **Yes or No**
e) What therapies will this medication be given in combination with? _____
_____

□ **Dysfunctional (Abnormal) Uterine Bleeding**

a) Has the member undergone Endometrial Ablation? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions (including frequency):_____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Menorrhagia (Heavy bleeding)/ Excessive or frequent menstruation (ICD-9 code 626.2)**

a) What is the heavy bleeding associated with? (If it is due to one of the listed diagnoses, please also choose that diagnosis and answer related questions).

_____

□ **Suppression of Menstruation or Ovarian Protection after Transplant**

a) Is the member post-Bone Marrow Transplant? **Yes or No**
b) Is the member premenopausal? **Yes or No**

□ **Gender Identity Disorder/Gender Incongruence or Gender Dysphoria**

For Adolescent Members:

a) Is the member 10-19 years of age? **Yes or No**
b) Has the member undergone surgery for gender reassignment (e.g. gonadectomy)? **Yes or No**
c) Does the member suffer from a psychiatric comorbidity that interferes with the diagnostic work-up or treatment? **Yes or No**
d) Will the member be psychological and social support during treatment? **Yes or No**

For Adult Members:

a) Is the member 20 years of age or older? **Yes or No**
b) Is the member receiving gender-affirming hormone therapy (e.g., testosterone, estrogen) together with GnRH **Yes or No**
c) Has the member undergone surgery for gender reassignment (e.g. gonadectomy)? **Yes or No**

□ **Other**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**.