



# Nevada Medicaid Molina Healthcare Lupron® Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

<b>Member Information</b> (required)			<b>Provider Information</b> (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:		State:	Zip:	Office Street Address:	
Phone:			City:		State:
			Zip:		
<b>Medication Information</b> (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information</b> (required)					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Endometriosis <input type="checkbox"/> Gender dysphoria (formerly known as gender identity disorder) <input type="checkbox"/> Idiopathic or neurogenic central precocious puberty (CPP) <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Uterine leiomyomata (fibroids) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Endometriosis:</b> Has the recipient had an inadequate response, adverse reaction or contraindication to a nonsteroidal anti-inflammatory drug (NSAID)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Has the recipient had an inadequate response, adverse reaction or contraindication to a hormonal contraceptive? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
<b>Gender dysphoria (formerly known as gender identity disorder):</b> Is the requested medication being prescribed for the suppression of puberty? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Does the provider indicate a demonstrable knowledge of what gonadotropins medically can and cannot do and their social benefits and risks? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Does the recipient have a documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Has the recipient had a period of psychotherapy for a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Select if the recipient meets the definition of gender dysphoria characterized by the following: <input type="checkbox"/> A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex) <input type="checkbox"/> Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex <input type="checkbox"/> The disturbance is not concurrent with a physical intersex condition <input type="checkbox"/> The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning <input type="checkbox"/> The transsexual identity has been present persistently for at least two years <input type="checkbox"/> The disorder is not a symptom of another mental disorder or a chromosomal abnormality					
<b>Idiopathic or neurogenic central precocious puberty (CPP):</b> Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Is there an onset of secondary sex characteristics before age eight years (females) or nine years (males)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Lupron\_NevadaMedicaid\_2019Jul-W

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MHN-10/25/2021

**Uterine leiomyomata (fibroids):**

Is the recipient symptomatic?  Yes  No

Will documentation of the anticipated surgery date (or notation that surgery is planned once the fibroids shrink) or clinical rationale why surgical intervention is not required be submitted?\*  Yes  No

*\*Please note: Chart documentation of the above is required to be submitted along with this fax.*

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note:

This request may be denied unless all required information is received.

For urgent or expedited requests please call (833) 685-2103.

This form may be used for non-urgent requests and faxed to (844) 259-1689.