



Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462

Supprelin LA (histrelin acetate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication requested: <input type="checkbox"/> Supprelin LA: 50mg kit ICD10: _____ J-Code: _____ Dose: _____ Frequency of administration: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy					
**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis: <input type="checkbox"/> Central precocious puberty <input type="checkbox"/> Gender-dysphoric/gender-incongruent persons <input type="checkbox"/> Gender reassignment (female-to-male or male-to-female) <input type="checkbox"/> Peripheral precocious puberty (also known as GnRH-independent precocious puberty) <input type="checkbox"/> Other					

Clinical Information:

(if CPP) Does the patient have a pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.2 mIU/ml? Yes No

(if CPP) Did the patient have a pubertal luteinizing hormone (LH) response to a GnRH agonist stimulation test? Yes No

(if CPP) Has the patient tried ONE of the following: Fensolvi or Triptodur? Yes No

(if gender dysphoria/reassignment) Is the requested medication being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients? Yes No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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