

Request Form for Gonadotropin Releasing Hormone Agonists (GnRH) (i.e. Zoladex® or Lupron®)



Non-Urgent Requests: Fax to (866) 533-5498
To speak to a PerformRx representative: call (800) 578-0898
Form must be completed for processing.

Urgent Requests: Fax to (866) 546-7972
Note: urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the member's life, health, or ability to regain maximum functions.

Member's Name: _____	Member ID#: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____	Phone #: _____ Birth Date: _____
Provider Name: _____	NPI /License#: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Contact Person: _____ Phone #: _____	Fax #: _____
Drug: _____ Sig: _____	
Provider Signature _____ Start date: _____ End date _____ OR Treatment dates _____	

Is the member currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

SECTION A. Please check the corresponding diagnosis and provide information accordingly:

Advanced Prostatic Cancer **Advanced Breast Cancer**

Endometriosis (Please attach additional information if necessary)

- Was a diagnosis made via laparoscopy? Yes No
- Did the member receive oral contraceptives and/or NSAIDs as a first line treatment to manage the condition, or does the member have a documented medical reason for not receiving oral contraceptives and/or NSAIDs? Please explain _____
- Has the member had ≥ 6 months of Lupron or Zoladex therapy? Yes No
- If yes, please indicate why ≥ 6 months of treatment is warranted or attach additional information. _____
- Has the member already received 6 months of cumulative Lupron or Zoladex therapy? Yes No **IF YES PLEASE COMPLETE SECTION B**

Uterine Leiomyomata (Fibroids) (Please attach additional information if necessary)

- Did the member receive oral contraceptives and/or NSAIDs as a first line treatment to manage the condition or does the member have a documented medical reason for not receiving oral contraceptives and/or NSAIDs. Please explain _____
- Has the member had ≥ 3 months of Lupron or Zoladex therapy? Yes No
- If yes please indicate why ≥ 3 months of treatment is warranted or attach additional information. _____
- Has the member already received 6 months of cumulative Lupron or Zoladex therapy? Yes No **IF YES PLEASE COMPLETE SECTION B**
- Is the member receiving the drug solely for the management of anemia? (Hgb ≤ 10.2g/dl or Hct ≤ 30%) Yes No
- If yes please provide or attach the Hct and Hgb values _____
- Has the member tried iron therapy prior to this? Yes No
- If yes, please indicate drug regimen _____
- Is the member receiving treatment for uterine fibroids, i.e. to decrease uterine volume to manage symptoms (pelvic pressure, urinary frequency, bleeding) and for shrinkage size to allow surgical intervention? Yes No

Endometrial Thinning (for menorrhagia) (Please attach additional information if necessary)

- Is the member scheduled for an endometrial ablation for dysfunctional uterine bleeding? Yes No
- If yes please comment _____

Central Precocious Puberty (CPP) (Please attach additional information if necessary)

- Is there clinical diagnosis of CPP with onset of secondary sexual characteristics at less than age 8 in females and 9 in males? Yes No
- Is diagnosis confirmed by a pubertal response to a GnRH stimulation test AND/OR measurement of gonadotropins (FSH/LH)? Yes No
- If yes please indicate or attach FSH/LH level lab results _____
- Is bone age 1 year > than chronological age? Yes No Bone age is _____
- Has the member been evaluated to R/O tumors as a cause of CPP? Yes No
- Is the child a male > 12 or a female > 11 years of age? Yes No
- If yes please submit documented medical reason to continue treatment: _____

If other diagnosis, please specify. (Please attach additional information if necessary) _____

SECTION B. Please provide the following information if member has already received 6 months of cumulative therapy (Attach additional information if necessary)

- If yes, please submit DEXA scan results to evaluate member's bone mineral density or indicate results (e.g. T score or Z score) _____
- Based on the DEXA scan does the member have osteoporosis? Yes No
- If yes please indicate what therapy the member is receiving for treatment (e.g. Fosamax, Calcium plus Vitamin D) _____
- Is the member receiving or soon to be prescribed "add back" therapy (e. g. norethindrone acetate 5mg QD or other hormone replacement therapy)? Yes No
- If yes, please indicate the treatment regimen _____