Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Eligard

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Request Type:

☐ Initial - Go to 2 ☐ Continuation - Go to 8

Q2. Does the patient have a diagnosis of prostate cancer OR recurrent salivary gland tumors when the tumor is androgen receptor positive?

☐ Yes ☐ No

Q3. Is the requested medication be used for pubertal hormonal suppression in an adolescent patient?

☐ Yes ☐ No

Q4. Does the patient meet all of the following criteria?
A) The member has a diagnosis of gender dysphoria.
B) The member has reached Tanner stage 2 of puberty or greater.
C) The member's comorbid conditions are reasonably controlled.
D) The member has been educated on any contraindications and side effects to therapy.
E) The member has been informed of fertility preservation options.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. Is the requested medication being used for gender transition?

☐ Yes ☐ No

Q6. Does the patient meet all of the following:
A) The member has a diagnosis of gender dysphoria.
B) The member will receive Eligard concomitantly with gender-affirming hormones.
C) The member's comorbid conditions are reasonably controlled.
D) The member has been educated on any contraindications and side effects to therapy.
E) The member has been informed of fertility preservation options.

☐ Yes ☐ No

Q7. Is the requested medication being prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider for patients less than 18 years of age?

☐ Yes ☐ No

Q8. For continuation, what is the diagnosis?

☐ Salivary gland tumors – Go to 9
☐ Prostate cancer – Go to 10
☐ Pubertal hormonal suppression – Go to 11
☐ Gender transition – Go to 12

Q9. Is the patient experiencing clinical benefit from therapy and has not experienced an unacceptable toxicity?

☐ Yes ☐ No

Q10. Is the patient experiencing clinical benefit from therapy (e.g., serum testosterone less than 50 ng/dL) and has not experienced an unacceptable toxicity?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q11. Does the patient meet all of the following criteria?
A) The member has a diagnosis of gender dysphoria.
B) The member has previously reached Tanner stage 2 of puberty or greater.
C) The member's comorbid conditions are reasonably controlled.
D) The member has been educated on any contraindications and side effects to therapy.
E) Before the start of therapy, the member has been informed of fertility preservation options.

☐ Yes ☐ No ☐ NA

Q12. Does the patient meet all of the following criteria?
A) The member has a diagnosis of gender dysphoria.
B) The member will receive Eligard concomitantly with gender-affirming hormones.
C) The member's comorbid conditions are reasonably controlled.
D) The member has been educated on any contraindications and side effects to therapy.
E) Before the start of therapy, the member has been informed of fertility preservation options.

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

v2025