Print Form Reset Form

FLORIDA MEDICAID

Prior Authorization

Supprelin LA (histrelin acetate)

Maximum Length of Therapy = Date of Service

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number

Prescriber Fax Number

Prescriber Specialty: _____

Is this medication for precocious puberty?

○ Yes ○ No

If Yes, specify ICD: _____

Is the prescriber a pediatric endocrinologist?

○ Yes ○ No

Has the patient had a clinical course of either Lupron Depot-Ped or Synarel that has failed or was not tolerated (within the last six months)?

○ Yes ○ No

Note: Legible copies of progress notes describing these events are required, please attach.

Please submit measurement of blood concentration of total sex steroids, measurement of LH and FSH after stimulation with GnRH analog, and assessment of bone versus chronological age.

Prescriber's Signature: _____ DATE : _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727