

MEDICARE FORM Trelstar® (triptorelin pamoate)

Trelstar® (triptorelin pamoate) Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B: For other lines of business: Please use commercial form.

Note: Trelstar is non-preferred. The preferred product is Eligard. Eligard does not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and Allina Health Aetna Medicare members send request to:

Phone: 1-866-503-0857 (TTY: 711)

Fax: <u>1-844-268-7263</u>

Availity: https://www.aetna.com/health-care-professionals/resource-center/availity.html

For Aetna Medicare Advantage Virginia Dual Eligible Special Needs Plans (HMO D-SNP)

send request to:

Phone: <u>1-855-463-0933</u> Fax: <u>1-833-280-5224</u>

Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal

For Aetna Assure Premier Plus Medicare Advantage New Jersey Dual Eligible Special Needs Plans

(HMO D-SNP) send request to:

Phone: <u>1-844-362-0934</u> Fax: 1-833-322-0034

Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

For Aetna Better Health of Illinois Premier Medicare Medicaid Plan (MMP) send request to:

Phone: <u>1-866-600-2139</u> FAX: <u>1-855-320-8445</u>

Availity: https://www.aetnabetterhealth.com/illinois/providers/portal

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:

Phone: <u>1-855-364-0974</u> Fax: <u>1-855-734-9389</u>

Availity: https://www.aetnabetterhealth.com/ohio/providers/portal

For Aetna Better Health of Michigan Premier Medicare Medicaid Plan (MMP) send request to:

Phone: <u>1-855-676-5772</u> Fax: <u>1-844-241-2495</u>

Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html



MEDICARE FORM Trelstar[®] (triptorelin pamoate) **Medication Precertification Request**

Page 2 of 3 (All fields must be completed and legible for precertification review.) For Medicare Advantage Part B: For other lines of business: Please use commercial form.

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Continuation of	therapy, Date of last treatment _						
Precertification Requested By:				Fax:			
A. PATIENT INFORMATION							
First Name:	Last Name:			DOB:			
Address:	<u>l</u>	City:		State:	ZIP:		
	ork Phone:	Cell Phone:	Emai				
Patient Current Weight: lbs or _		1	Allergies:	-			
B. INSURANCE INFORMATION	kys Fallent Height		Allergies.				
Aetna Member ID #:	Does nationt ha	ave other coverage?					
Group #:							
Insured:	Insured:						
Medicare: ☐ Yes ☐ No If yes, provi		Medicaid: ☐ Yes ☐	No If ves. provi	 ide ID #;			
C. PRESCRIBER INFORMATION	<u> </u>			ue 12			
First Name:	Last Name:		(Check One	e):	☐ D.O. ☐ N.P. ☐ P.A.		
Address:		City:		State:	ZIP:		
Phone: Fax:	St Lic #:	NPI #:	DEA #:	Olulo.	UPIN:		
Provider Email:				Dhanai	UPIIN.		
	Office Contact I			Phone:			
Specialty (Check one): Oncologist	<u>=</u>	·					
D. DISPENSING PROVIDER/ADMINIS	TRATION INFORMATION	I					
Place of Administration:	11- Office		rovider/Pharmacy				
	cian's Office	I = = = = = = = = = = = = = = = = = = =	office [armacy		
Outpatient Infusion Center Ph Center Name:	ione.	☐ Specialty P	harmacy L	Other			
	none:	Name:					
Agency Name:		Address:			_		
Administration code(s) (CPT):				State:	ZIP:		
Address:		Phone:					
City:		TIM:					
Phone:							
TIN: NPI:	PIN:						
E. PRODUCT INFORMATION							
Request is for: Trelstar (triptorelin pa	mosta) Dosa:	Frequenc					
F. DIAGNOSIS INFORMATION - Please		•					
Primary ICD Code:				CD Code:			
G. CLINICAL INFORMATION - Requir			all preceruiication	requesis.			
For Initiation Requests (clinical documentation required for all requests): Note: Trelstar is non-preferred for prostate cancer and gender dysphoria. The preferred product is Eligard. Eligard does not require precertification.							
			S Eligaro. Eligaro	does not red	quire precertification.		
☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days? ☐ Yes ☐ No Has the patient had a trial and failure of Eligard?							
☐ Yes ☐ No Has the patient had a trial and failure of Eligard? When was the member's trial and failure of Eligard? ———————————————————————————————————							
Please describe the nature of the failure of Eligard Please describe the nature of the failure of Eligard							
☐ Yes ☐ No Has the patient had an adverse reaction to Eligard?							
When was the member's adverse reaction to Eligard?							
Please describe the nature of the adverse reaction to Eligard							
Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Eligard when indicated for the patient's diagnosis.							
Gender dysphoria							
☐ Yes ☐ No Is the requested medication being prescribed for pubertal suppression in an adolescent patient? ☐ Yes ☐ No Is the patient undergoing gender reassignment?							
☐ Yes ☐ No Will the patient receive the requested medication concomitantly with gender affirming hormones?							
Please indicate the Tanner Stage of puberty the patient has reached:							
☐ Stage I ☐ Stage II ☐ Stage IV ☐ Stage V ☐ Unknown							



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB				
G. CLINICAL INFORMATION (contin	(ued) – Required clinical inform	ation must be completed in its entire	ety for all precertification requests				
For Initiation Requests continued (clinic			ior an processmeation requests.				
☐ Preservation of ovarian function							
☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?							
☐ Endometrial hyperplasia							
☐ Yes ☐ No Does the patient have non-atypical endometrial hyperplasia?							
☐ Endometriosis/Uterine leiomyoma							
How long has the patient received previous therapy with Trelstar?							
Fibrocystic breast changes							
☐ Yes☐ No Does the patient have benign fibrocystic mastopathy?☐ Yes☐ No Will Trelstar be used as a single agent or in combination with tamoxifen or cyproterone?							
Breast cancer							
Yes No Will the requested drug be used for ovarian suppression?							
Yes No Is the disease hormone-receptor positive? If yes, documentation or hormone receptor testing results must be submitted upon request.							
☐ Yes ☐ No Is the patient premenopausal?							
☐ Yes ☐ No Does the patient have a higher risk for recurrence (e.g., young age, high-grade tumor, lymph-node involvement)?							
Yes No Will the requested me	edication be used in combination	with endocrine therapy?					
☐ Prostate cancer							
For Continuation Requests (clinical doc	umentation required for all rec	quests):					
Gender dysphoria	ng henefit from therapy while on t	he current regimen?					
☐ Yes ☐ No Is the patient receiving benefit from therapy while on the current regimen? ☐ Yes ☐ No Has the member experienced an unacceptable toxicity?							
☐ Yes ☐ No Is the requested medication being prescribed for pubertal suppression in an adolescent patient?							
T Yes ☐ No Is the patient undergoing gender transition?							
☐ Yes ☐ No Will the patient receive the requested medication concomitantly with gender affirming hormones?							
Please indicate the Tanner Stage of puberty the patient has reached:							
☐ Stage I☐ Stage II☐ Stage IV☐ Stage V☐ Unknown☐ Preservation of ovarian function							
Yes No Is the patient premenopausal and still undergoing chemotherapy?							
☐ Yes ☐ No Is the patient receiving benefit from therapy while on the current regimen?							
☐ Yes ☐ No Has the member exp	erienced an unacceptable toxicit	y?					
☐ Prostate cancer							
Yes No Has the patient had prior therapy with Trelstar within the last 365 days?							
☐ Yes ☐ No Has the patient experienced clinical benefit to therapy while receiving the requested drug (e.g., serum testosterone less than 50 ng/dl)? ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?							
H. ACKNOWLEDGEMENT							
Request Completed By (Signature Re	equired):		Date:/ /				
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.							

The plan may request additional information or clarification, if needed, to evaluate request.