Zoladex® (goserelin acetate) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Endocrinologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Zoladex (goserelin acetate) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required for all requests):

☐ **Chronic anovulatory uterine bleeding (use as an endometrial thinning agent 3.6 mg only)**
☐ Yes ☐ No Will the requested medication be used for treatment as an endometrial thinning agent prior to endometrial ablation or resection for dysfunctional uterine bleeding?
→ Please indicate how many months the patient has already received the requested medication for this indication: _____

☐ **Dysfunctional uterine bleeding (use as an endometrial thinning agent 3.6 mg only)**
☐ Yes ☐ No Will the requested medication be used for treatment as an endometrial thinning agent prior to endometrial ablation or resection for dysfunctional uterine bleeding?
→ Please indicate how many months the patient has already received the requested medication for this indication: _____

☐ **Endometriosis (3.6 mg only)**
Please indicate how many months the patient has already received the requested medication for this indication: _____

☐ **Prostate cancer (3.6 mg and 10.8 mg)**
☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Eligard?

☐ **Uterine leiomyomata (fibroids) (3.6 mg only)**
Please indicate how many months the patient has already received the requested medication for this indication: _____

For Continuation Requests (clinical documentation required for all requests):

☐ **Prostate cancer**
☐ Yes ☐ No Has the patient experienced clinical benefit to therapy while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while on the current regimen?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **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 requests.