Print Reset

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's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

Prescriber Specialty: _____

1. **Is this medication for precocious puberty?**
   ☐ Yes ☐ No

If Yes, specify ICD: _____

2. **Is the prescriber a pediatric endocrinologist?**
   ☐ Yes ☐ No

3. **Has the patient had a clinical course of either Lupron Depot-Ped, Triptodur, or intranasal 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: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
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Prior Authorization
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