PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 5/2015
VERIFIED: 2/2021
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Lupaneta Pack

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Lupaneta Pack.

Brand Name (select from list of drugs shown)

Lupaneta Pack (leuprolide inj-norethindrone tabs)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of endometriosis? [If no, no further questions.]	Yes No
2	Is this a request for endometriosis retreatment? [If no, no further questions.]	Yes No
3	Has the patient previously received a 6-month retreatment course of therapy with the requested drug?	Yes No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date