



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Synarel

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Synarel Other _____
2. What is the diagnosis?
 Central Precocious Puberty (CPP)
 Other _____
3. **What is the ICD9?** _____
4. How old is the patient? _____ **years**
5. Is Synarel prescribed by and will patient be monitored by a pediatric endocrinologist? Yes No
6. What is the gender of the patient? Female Male
7. Is the patient currently receiving Synarel for CPP? **If yes, no further questions* Yes No
8. Has the patient been ruled out for any type of tumor with MRI of brain or CT of brain if MRI is contraindicated? Yes No
9. Does the patient have an advanced bone age of greater than 1 year advanced age? Yes No
10. Does the patient have elevated basal luteinizing hormone (LH) level and/or elevated stimulated LH level (greater than 5 IU/D)? Yes No
11. How old was the patient at the onset of secondary sexual characteristics? _____ **years**

*Only answer questions #12-13 if the patient is a **FEMALE***

12. Does the patient have an early onset of advanced pubertal staging as evidenced by breast development or menses? Yes No
13. Does the patient have pubertal basal or stimulated estradiol levels? Yes No

*Only answer questions #14-15 if the patient is a **MALE***

14. Does the patient have an early onset of advanced pubertal staging as evidenced by testicular enlargement? Yes No

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Synarel Centene - MD Fax 7/1/2011

Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

15. Does the patient have pubertal basal or stimulated testosterone levels? Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Synarel Centene - MD Fax 7/1/2011