



LUPRON DEPOT
(leuprolide acetate)
(Eligard, Viadur)

Please call 1-800-972-8088 for Assistance

Clinical Conditions	Documents	Check List <input type="checkbox"/>
Prostate Cancer	1. If you are not the prescribing physician, please provide a copy of the prescription and/or order sheet.	<input type="checkbox"/>
	2. Documentation that the patient has advanced prostate cancer with metastasis; and	<input type="checkbox"/>
	3. Treatment is being prescribed as palliative therapy as an alternative to surgery or estrogen administration; or	<input type="checkbox"/>
	4. other hormone therapies are intolerable, surgical castration is not an option; and there are no alternative therapies available; or	<input type="checkbox"/>
	5. Documentation that prostate cancer therapy for Stage B2 through C is locally confined.	<input type="checkbox"/>
Breast Cancer	1. If you are not the prescribing physician, please provide a copy of the prescription and/or order sheet.	<input type="checkbox"/>
	2. Is this patient currently on aromatase inhibitor therapy?	<input type="checkbox"/>
	3. Documentation of advanced or metastatic breast cancer in premenopausal and perimenopausal women.	<input type="checkbox"/>
	4. Documentation of advanced or metastatic breast cancer in perimenopausal women with hormone receptor positive disease with or without concurrent tamoxifen or ovarian oppression.	<input type="checkbox"/>
Endometriosis	1. If you are not the prescribing physician, please provide a copy of the prescription and/or order sheet.	<input type="checkbox"/>
	2. Required documentation: <ul style="list-style-type: none"> • History and physical; and <input type="checkbox"/> • Of prior treatment (tried and failed); and <input type="checkbox"/> • Surgical reports; and <input type="checkbox"/> • Pathology reports; and <input type="checkbox"/> • Physician's Treatment and visit notes. <input type="checkbox"/> 	<input type="checkbox"/>

Uterine Leiomyomata (fibroid)	1. If you are not the prescribing physician, please provide a copy of the prescription and/or order sheet.	<input type="checkbox"/>
	2. Required documentation: <ul style="list-style-type: none"> • History and physical; and <input type="checkbox"/> • Of prior treatment (tried and failed); and <input type="checkbox"/> • Surgical reports; and <input type="checkbox"/> • Pathology reports; and <input type="checkbox"/> • Physician's Treatment and visit notes. <input type="checkbox"/> 	<input type="checkbox"/>
Infertility	1. Check Member Benefit Contract for coverage of Infertility	<input type="checkbox"/>
	2. If you are not the prescribing physician, please provide a copy of the prescription and/or order sheet.	<input type="checkbox"/>
	3. Documentation of luteinizing hormone levels.	<input type="checkbox"/>
For additional information please see HCSC Medical Policy RX501.041		