MEDICARE FORM
Zoladex® (goserelin acetate) Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Zoladex is non-preferred. The preferred product is Eligard. Eligard does not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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

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 Initiation Requests (clinical documentation required for all requests):

Note: Zoladex is non-preferred for prostate cancer, gender dysphoria and recurrent androgen receptor positive salivary gland tumors. The preferred product is Eligard. Eligard does not require precertification.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure of Eligard?
→ When was the member's trial and failure of Eligard? _____
→ Please describe the nature of the failure of Eligard _____
☐ Yes ☐ No Has the patient had an adverse reaction to Eligard?
→ When was the member's adverse reaction to Eligard? _____
→ Please describe the nature of the adverse reaction to Eligard _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Eligard when indicated for the patient's diagnosis.

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Zoladex 3.6 mg requests only:

☐ **Breast cancer**
Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown

☐ **Chronic anovulatory uterine bleeding**
☐ Yes ☐ No Will the requested medication be used as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding?
→ ☐ Yes ☐ No Will the requested medication be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia?

☐ **Dysfunctional uterine bleeding**
☐ Yes ☐ No Will the requested medication be used as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding?
→ ☐ Yes ☐ No Will the requested medication be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia?

☐ **Endometriosis**
Please indicate how many months has the patient already received the requested medication for this indication:
☐ 6 months or greater ☐ Less than 6 months

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested medication being prescribed for pubertal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive the requested medication concomitantly with gender affirming hormones?
→ Please indicate the Tanner Stage of puberty the patient has reached:
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

☐ **Preservation of ovarian function**
☐ Yes ☐ No Is the patient premenopausal?
☐ Yes ☐ No Is the patient premenopausal and undergoing chemotherapy?

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
☐ Yes ☐ No Is the requested medication being requested to prevent recurrent menstrual related attacks in acute porphyria?
☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?

☐ **Prostate cancer**

☐ **Uterine leiomyomata (fibroids)**
☐ Yes ☐ No Will the requested medication be given prior to surgery?

For Zoladex 10.8 mg requests only:

☐ **Breast cancer**
Please indicate the patient's hormone receptor (HR) status: ☐ HR-positive ☐ HR-negative ☐ Unknown

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested medication being prescribed for pubertal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive the requested medication concomitantly with gender affirming hormones?
→ Please indicate the Tanner Stage of puberty the patient has reached:
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

☐ **Prostate cancer**
☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Eligard?
☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Firmagon?

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

☐ **Breast cancer**
☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Gender dysphoria**
☐ Yes ☐ No Is the requested medication being prescribed for pubertal suppression in an adolescent patient?
→ ☐ Yes ☐ No Is the patient undergoing gender transition?
☐ Yes ☐ No Will the patient receive the requested medication concomitantly with gender affirming hormones?
→ Please indicate the Tanner Stage of puberty the patient has reached:
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Stage V ☐ Unknown

☐ **Preservation of ovarian function**
☐ Yes ☐ No Is the patient premenopausal and still undergoing chemotherapy?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Prevention of recurrent menstrual related attacks in acute porphyria**
- ☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

☐ **Prostate cancer**
- ☐ Yes ☐ No Has the patient had prior therapy with Zoladex within the last 365 days?
- ☐ Yes ☐ No Has the patient experienced clinical benefit to therapy while receiving the requested drug (e.g., serum testosterone less than 50 ng/dl)?
- ☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

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.