Prescriber Criteria Form

Eligard 2024 PA Fax 5263-A v1 010124.docx
Eligard (leuprolide acetate for injectable suspension)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Eligard (leuprolide acetate for injectable suspension).

Drug Name:
Eligard (leuprolide acetate for injectable suspension)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of prostate cancer? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of recurrent androgen receptor positive salivary gland tumors?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____