# Pharmacy Pre-Authorization Criteria

<table>
<thead>
<tr>
<th>DRUG</th>
<th>Synarel® (nafarelin acetate) nasal solution</th>
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<tbody>
<tr>
<td>POLICY #</td>
<td>11120</td>
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| INDICATIONS| Synarel is indicated for the treatment of central precocious puberty (CPP) in children of both sexes.  
Synarel is indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions. |
| CRITERIA   | ConnectiCare considers Synarel to be medically necessary for patients who meet the following criteria:  
• Patient has a diagnosis of central precocious puberty  
OR  
• Patient is greater than 18 years of age and has documented endometriosis  
AND  
• Patient has an intolerance to, or treatment failure of oral contraceptives |
| LIMITATIONS| If the above criteria are met patients with a diagnosis of central precocious puberty will be granted authorization for up to 1 year. Subsequent approvals will be granted with physician chart notes documenting tolerability and disease stability.  
If the above criteria are met patients with a diagnosis of endometriosis will be granted for 6 months. Retreatment with additional courses cannot be recommended since safety data for retreatment are not available. |
| REFERENCES | 1. Synarel full prescribing information . Pharmacia, Chicago IL.  
| P&T REVIEW HISTORY | 3/05, 6/07, 6/08, 9/09, 9/10, 12/11, 10/12, 10/13, 10/14, 11/15, 2/16, 2/17, 1/18 |
| REVISION RECORD | 3/05, 6/07, 6/08, 9/09, 9/10, 12/11, 10/12, 10/13, 10/14, 11/15, 2/16, 2/17, 1/18 |