

Prior Authorization Request Form for Fertility Drugs

Non-Urgent Request Urgent Circumstances (please include rationale Section IV)

This form is to be used by prescribers only.

I. Prescriber Information (please print)					
Prescriber Name:			Office Contact:		
Prescriber NPI:			Phone:		
Specialty:			Fax:		
II. Member Information (please print)					
Member name:			Phone:		
Member ID #:		Date of Birth:	Height:		Weight:
Required to confirm address for any correspondence related to prior authorization(s)					
Address:		City:		State:	Zip:
Medication allergies:					
III. Drug Information (please identify (X) all therapies required for the protocol included in this request and fully complete the blank fields)					
Drug name & Strength			Directions	Quantity	Days Supply
Ovulation Stimulants-Gonadotropins					
Ovidrel		250 MCG/0.5ML			
Gonal-f		300 UNIT/0.5ML	450 IU MDV		
		450 UNIT/0.75ML	Other:		
Follistim AQ		300 UNT cartridge	900 UNT cartridge		
		600 UNT cartridge	Other:		
Menopur		75 UNIT SQ soln, vial			
Chorionic Gonadotropin		10,000 UNIT IM soln, vial	Other:		
		Other:			
GnRH/LHRH Antagonists					
Cetrotide		0.25 MG SQ kit			
Ganirelix Acetate		250 MCG/0.5ML SQ soln, prefilled syringe			
Other:					
LHRH Agonists					
Leuprolide Acetate		1 MG/0.2 ML inj. kit	Other:		
Other:					
IV. Diagnosis/Treatment/Protocol					
Diagnosis:		Treatment:		Protocol:	Start Date (if known):
Prescriber/Agent Signature:					Date:

Information on this form is Protected Health Information (PHI) and subject to all privacy and security under HIPAA.

Appropriate clinical information (including lab reports, when appropriate) to support the request on the basis of medical necessity must be submitted. PharmAvail is unable to evaluate any request without office notes.