univera HEALTHCARE

Drug Prior Authorization FAX Form

Infertility
Cetrotide, Cetrorelix Acetate, chorionic gonadotropin (hCG), Endometrin, Follistim AQ, Fyremadel, Ganirelix, Gonal-F, Leuprolide, Menopur, Novarel, Ovidrel, Pregnyl
(Self-Administration)
Rx Benefit

Complete this form and fax to:

☐ **Pharmacy (Self-admin)**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

Specialty Medications can be filled at:

☐ **Freedom Fertility Pharmacy**
(A fully owned subsidiary of Accredo Health)
Fax #: 1-888-660-4283
Phone #: 1-800-660-4283

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:
Location of Infusion: ☐ **Prescriber office** ☐ **Home/Homecare agency:**_____ ☐ **Outpatient facility** ☐ **Other:** _____	
Servicing Prescriber NPI (if different from the ordering prescriber):	
Provide address for medication shipping (if applicable):	

Medication/Medical and Dispensing Information

1. Check the drug(s) which apply to this request.

☐ Centrotide	☐ Cetrorelix Acetate	☐ Chorionic gonadtropin	☐ Endometrin
☐ Follistim AQ	☐ Fyremadel	☐ Ganirelix	☐ Gonal-f
☐ Gonal-f RFF	☐ hCG	☐ Leuprolide	☐ Menopur
☐ Novarel	☐ Ovidrel	☐ Pregnyl	☐

Medication (HCPCS)	Dose	Frequency/Form	Height	Weight (lbs. or kg)	Procedure Code

2. Provide anticipated units per dose, cycle length and quantity prescribed:

Medication	Dose	Units___ per day X total # ___of days		= _____ (Total Units per month)

3. Diagnosis/ICD-10 Code: _____

4. Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: _____

5. **RECERTIFICATION**, Does the prescriber **attest** the patient has been monitored for increased sperm count while taking the requested medication? Prescriber Attestation Signature: _____	☐ **Yes** ☐ **No**

Questions/Indications for Medical Necessity

**** See the Infertility Medications Policy (Pharmacy-24) for full Prior Authorization criteria ****

1. Does the patient have a diagnosis of infertility for at least twelve (12) months **OR** six (6) months for a female thirty-five years of age or older)?	☐ **Yes** ☐ **No**
2. Is the requested medication being used IN CONJUNCTION with an in vitro fertilization procedure (IVF)?	☐ **Yes** ☐ **No**
3. Is the requested medication being used IN CONJUCTION with Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), reversal of elective sterilization, cloning or medical/surgical procedures deemed experimental in accordance with clinical guidelines?	☐ **Yes** ☐ **No**
4. Is the requested medication being used for fertility preservation when a medical treatment may directly or indirectly cause "Iatrogenic infertility"? If **YES**- please explain: _____	☐ **Yes** ☐ **No**
5. If the requested medication is being used for the induction of spermatogenesis: a. Has the patient had a trial of human chorionic gonadotropin alone to normalize serum testosterone? (if the request is for combination therapy) b. If **YES** does the provider attest the patient has normal serum testosterone levels (300-1000ng/dL)? Prescriber Attestation Signature: _____	☐ **Yes** ☐ **No**
6. If prescribing **Follistim**: Has the patient had a previous trial of Gonal-F?	☐ **Yes** ☐ **No**
7. Is the requested medication is being used for another indication, please specify: _____	☐ **Yes** ☐ **No**

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge.