



Please complete ALL information below and fax your request to 1-888-671-5285

Cetrotide® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Infertility

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the following exists:

- Unexplained infertility
- Endometriosis
- Male factor infertility
- Tubal factor infertility
- Any other indication for assisted reproductive technology (ART) (e.g., recurrent pregnancy loss, cervical or uterine factor infertility)

Will Cetrotide be used for the development of multiple follicles (controlled ovarian hyperstimulation)? Yes No

Will Cetrotide be used in conjunction only with assisted reproductive technology (ART)? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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