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

Cetrotide® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

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.