



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

Crinone® 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:
<input type="checkbox"/> Check if generic substitution is acceptable <input type="checkbox"/> Check if request is for continuation of therapy		Directions for Use:

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Intended for use as part of an Assisted Reproductive Technology (ART) treatment for infertile women <input type="checkbox"/> Secondary amenorrhea <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Quantity limit requests:	
What is the quantity requested per MONTH? _____	
Has the patient had a trial and failure, intolerance, or contraindication to Endometrin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the requested medication prescribed by or in consultation with a reproductive endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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