



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

Follistim AQ® 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:

- Controlled ovarian hyperstimulation
- Male hypogonadotropic hypogonadism
- Ovulation induction
- Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is this medication prescribed by or in consultation with a reproductive endocrinologist? Yes No

Has the patient had trial and failure, intolerance, or contraindication to Gonal-f/Gonal-f RFF (follitropin alfa)? Yes No

For controlled ovarian hyperstimulation, also answer the following:

Does the patient have a diagnosis of infertility? Yes No

Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? Yes No

Is this medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? Yes No

For male hypogonadotropic hypogonadism, also answer the following:

Select the diagnosis:

- Male primary hypogonadotropic hypogonadism
- Male secondary hypogonadotropic hypogonadism

Is this medication being used for induction of spermatogenesis? Yes No

Is the infertility due to primary testicular failure? Yes No

For ovulation induction, also answer the following:

Does the patient have a diagnosis of anovulatory infertility? Yes No

Is the infertility due to primary ovarian failure? Yes No

Is this medication being used for the induction of ovulation? 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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