FUTURE SCRIPTS

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

Follistim AQ® 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:

❑ 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.