FUTURE SCRIPTS

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

Novarel® & Pregnyl® (chorionic gonadotropin) 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	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Hypogonadotropic hypogonadism
- ❑ Controlled ovarian hyperstimulation (development of multiple follicles)
- ❑ Ovulation induction
- ❑ Prepubertal cryptorchidism
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For male hypogonadotropic hypogonadism, answer the following:

Does the patient have male hypogonadism secondary to pituitary deficiency? ❑ **Yes** ❑ **No**

Does the patient have low testosterone (below normal reference level provided by the physician's laboratory)? ❑ **Yes** ❑ **No**

Does the patient have low LH (below normal reference level provided by the physician's laboratory)? ❑ **Yes** ❑ **No**

Does the patient have low FSH (below normal reference level provided by the physician's laboratory)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

For controlled ovarian hyperstimulation (development of multiple follicles), answer the following:

Does the patient have a diagnosis of infertility? ❑ **Yes** ❑ **No**

Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? ❑ **Yes** ❑ **No**

For ovulation induction, answer the following:

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

Is the infertility due to primary ovarian failure? ❑ **Yes** ❑ **No**

Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? ❑ **Yes** ❑ **No**

For prepubertal cryptorchidism, answer the following:

Does the patient have a diagnosis of prepubertal cryptorchidism not due to anatomical obstruction? ❑ **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.