



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

## Novarel® & Pregnyl® (chorionic gonadotropin) 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 <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

### 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?**

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Please note: This request may be denied unless all required information is received.

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