



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

### Bravelle® 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:**

- Development of multiple follicles as part of an assisted reproductive technology (ART) cycle in ovulatory women who have previously received pituitary suppression
- Induction of ovulation in women who have previously received pituitary suppression
- Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Does the patient have inadequate response or inability to tolerate Gonal-f?  Yes  No

**Quantity Limit Requests:**

What is the quantity requested per MONTH? \_\_\_\_\_

Is there documentation of the inability to reach the requested dose with commercially available dosage forms?  Yes  No

Is there documentation the dose requested is medically necessary?  Yes  No

If YES, please specify: \_\_\_\_\_

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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