FUTURE SCRIPTS

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

# Bravelle® 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<br>❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## 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?**

_____

_____

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