INFERTILITY

Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

PATIENT INFORMATION

Date: ____________________

Name: ____________________

ID: ____________________

Date of Birth: ____________________

Request Initiated For: ____________________

PRESCRIBER INFORMATION

Name: ____________________

Office Telephone: ____________________

Office Fax: ____________________

Specialty: ____________________

NPI#: ____________________

DRUG(S) PRESCRIBED *Please select the drug(s) that will be prescribed throughout the course of treatment.*

❑ **Gonal-f*** ❑ Cetrotide ❑ ganirelix ❑ Ovidrel ❑ hCG ❑ leuprolide acetate
❑ Menopur ❑ Novarel ❑ Follistim AQ ❑ Pregnyl ❑ Other ____________________

**Gonal-f is the preferred product over Follistim AQ for your patient's health plan.*

PATIENT DIAGNOSIS/PROCEDURE & ICD-10 CODE

❑ Ovulation induction (e.g., intrauterine insemination [IUI])
❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI])
❑ Prepubertal cryptorchidism
❑ Hypogonadotropic hypogonadism
❑ Other ____________________

ICD-10: ____________

PREFERRED DRUG *Please complete this section if Follistim AQ is being prescribed.*

1. The preferred product for your patient's health plan is Gonal-f. Can the patient's treatment be switched to Gonal-f? ***If Yes, fax a new prescription to the pharmacy and skip to next section.*** ❑ Yes ❑ No
2. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #4*
3. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to next section.*
4. Does the patient have a documented contraindication to Gonal-f or any of its drug components? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to next section.*** ❑ Yes ❑ No
5. Has the patient experienced a documented intolerable adverse event to Gonal-f? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

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MEDICAL BENEFIT PLAN APPROVAL INFORMATION

1. Is coverage for the drug(s) being requested for a procedure that has been approved by the patient's medical benefit plan?
   ❒ Yes - Indicate the medical authorization number: ______________________
   ❒ No
   ❒ Not applicable, patien'ts medical benefit plan does not require precertification for the requested procedure

2. What type of procedure has been approved by the medical benefit plan **OR** the patient will be undergoing?
   If procedure indicated below has been previously approved by the plan, no further questions.
   ❑ Ovulation induction (e.g., intrauterine insemination [IUI])
   ❑ Assisted reproductive technology (e.g., in vitro fertilization [IVF], frozen embryo transfer, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI])
   ❑ Mature oocyte cryopreservation
   ❑ Embryo cryopreservation
   ❑ Preimplantation genetic diagnosis
   ❑ Other ____

DIAGNOSIS/PROCEDURE SPECIFIC QUESTIONS

OVULATION INDUCTION, ASSISTED REPRODUCTIVE TECHNOLOGY - FOLLISTIM AQ, GONAL-F, MENOPUR

1. How many cycles of clomiphene citrate (Clomid, Serophene) has the patient completed?_______________ cycles
   If three or more cycles have been completed, no further questions.

2. Does the patient have a risk factor for poor ovarian response to clomiphene?
   If Yes, no further questions ❑ Yes ❑ No

3. Does the patient have a contraindication or exclusion to therapy with clomiphene? ❑ Yes ❑ No

OVULATION INDUCTION, ASSISTED REPRODUCTIVE TECHNOLOGY - LEUPROLIDE ACETATE

1. What is the intent of therapy?
   ❒ Inhibition of premature luteinizing hormone (LH) surges
   ❒ Ovulation trigger
   ❒ Other ____________________________

OVULATION INDUCTION, ASSISTED REPRODUCTIVE TECHNOLOGY - CETROTIDE, GANIRELIX

1. What is the intent of therapy?
   ❒ Inhibition of premature luteinizing hormone (LH) surges
   ❒ Other ____________________________

HYPOGONADOTROPIC HYPOGONADISM

1. Does the patient have a low pretreatment testosterone level? ❒ Yes ❒ No

2. Does the patient have:
   ❒ Low or low-normal follicle stimulating hormone (FSH) level
   ❒ Low or low-normal luteinizing hormone (LH) level
   ❒ Neither

AUTHORIZATION

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

If additional information is needed, the person below will be contacted:

Office Contact Person: ______________________________ **Contact Phone:** ___________________________

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