

Ticket #: _____ Request Date: _____ Request Time: _____

Cetrotide® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Infertility	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical Information:	
Select if the following exists:	
<input type="checkbox"/> Unexplained infertility	
<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Male factor infertility	
<input type="checkbox"/> Tubal factor infertility	
<input type="checkbox"/> Any other indication for assisted reproductive technology (ART) (e.g., recurrent pregnancy loss, cervical or uterine factor infertility)	
Will Cetrotide be used for the development of multiple follicles (controlled ovarian hyperstimulation)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Cetrotide be used in conjunction only with assisted reproductive technology (ART)? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

Authorized Medical Signature:	
Telephone:	Date:

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.
Office use only: Cetrotide_Comm_2017Mar

Cetrotide® Prior Authorization Request Form (Page 2 of 2)
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When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

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