

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

Gonal-f® & Gonal-f RFF® Prior Authorization Request Form (Page 1 of 2)
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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 requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below: <input type="checkbox"/> Controlled ovarian hyperstimulation <input type="checkbox"/> Male hypogonadotropic hypogonadism <input type="checkbox"/> Ovulation induction <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Prescriber's Specialty: Is this medication prescribed by or in consultation with a reproductive endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For controlled ovarian hyperstimulation, answer the following: Does the patient have a diagnosis of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For male hypogonadotropic hypogonadism, answer the following: Select the diagnosis: <input type="checkbox"/> Male primary hypogonadotropic hypogonadism <input type="checkbox"/> Male secondary hypogonadotropic hypogonadism Is this medication being used for induction of spermatogenesis? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the infertility due to primary testicular failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For ovulation induction, answer the following: Does the patient have a diagnosis of anovulatory infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the infertility due to primary ovarian failure? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this medication being used for the induction of ovulation? <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?

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.
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Authorized Medical Signature:	
Telephone:	Date:

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.

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