ProCare Rx

Gonal-f® & Gonal-F RFF®

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

Gonal-f® & Gonal-f RFF® Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Controlled ovarian hyperstimulation
- ❑ Male hypogonadotropic hypogonadism
- ❑ Ovulation induction
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is this medication prescribed by or in consultation with a reproductive endocrinologist? ❑ **Yes** ❑ **No**

For controlled ovarian hyperstimulation, answer the following:

Does the patient have a diagnosis of infertility? ❑ **Yes** ❑ **No**

Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? ❑ **Yes** ❑ **No**

Is the medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? ❑ **Yes** ❑ **No**

For male hypogonadotropic hypogonadism, answer the following:

Select the diagnosis:

- ❑ Male primary hypogonadotropic hypogonadism
- ❑ Male secondary hypogonadotropic hypogonadism

Is this medication being used for induction of spermatogenesis? ❑ **Yes** ❑ **No**

Is the infertility due to primary testicular failure? ❑ **Yes** ❑ **No**

For ovulation induction, answer the following:

Does the patient have a diagnosis of anovulatory infertility? ❑ **Yes** ❑ **No**

Is the infertility due to primary ovarian failure? ❑ **Yes** ❑ **No**

Is this medication being used for the induction of ovulation? ❑ **Yes** ❑ **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?

_____

_____

_____

Gonal-f® & Gonal-f RFF® Prior Authorization Request Form (Page 2 of 2)

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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.