

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

Ovidrel® (chorionic gonadotropin) 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:
<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"/> Hypogonadotropic hypogonadism <input type="checkbox"/> Controlled ovarian hyperstimulation (development of multiple follicles) <input type="checkbox"/> Ovulation induction <input type="checkbox"/> Prepubertal cryptorchidism <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
For male hypogonadotropic hypogonadism, answer the following: Does the patient have male hypogonadism secondary to pituitary deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have low testosterone (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have low LH (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have low FSH (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No Reauthorization: Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For controlled ovarian hyperstimulation (development of multiple follicles), answer the following: Does the patient have a diagnosis of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? <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 Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For prepubertal cryptorchidism, answer the following: Does the patient have a diagnosis of prepubertal cryptorchidism not due to anatomical obstruction? <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?

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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.