Member Name: **DOB:** **PA Number:**

INFERTILITY

Prior Authorization Request

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*** ❑ **Ovidrel**** ❑ Cetrotide ❑ ganirelix ❑ hCG ❑ leuprolide acetate
❑ Menopur ❑ Novarel ❑ Follistim AQ ❑ Pregnyl ❑ Other _____

**Gonal-F is the preferred product when prescribing Follistim AQ.*
***Ovidrel is the preferred product when prescribing hCG, Novarel and Pregnyl.*

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], intractyoplasmic sperm injection [ICSI]) ❑ Prepubertal cryptorchidism ❑ Hypogonadotropic hypogonadism
❑ Other _____

ICD-10: _____

PREFERRED DRUG: *Complete the section(s) below if non-preferred product(s) are being prescribed.*

Follistim AQ

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. Does the patient have a documented intolerable adverse event to Gonal-f? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

hCG, Novarel, Pregnyl

3. The preferred product for your patient's health plan is Ovidrel. Can the patient's treatment be switched to Ovidrel? ***If Yes, fax a new prescription to the pharmacy and skip to next section.*** ❑ Yes ❑ No

4. Does the patient have a documented contraindication to Ovidrel or any of its drug components? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to next section.*** ❑ Yes ❑ No

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

 Infertility ACSF SGM - 1/2020.

5. Does the patient have a documented intolerable adverse event to Ovidrel? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

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? ***ACTION REQUIRED: Attach laboratory results of testosterone level.*** ❒ Yes ❒ No
2. Does the patient have: ***ACTION REQUIRED: Attach laboratory results of FSH and LH levels.***
   ❒ 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: _____**

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