CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Infertility – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Fax: 888-249-6155

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 888-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.**

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**
Quantity:	**Frequency:**
Route of Administration:	**Expected Length of Therapy:**

Follistim AQ is the preferred product for your patient's health plan when prescribing Bravelle and/or Gonal-F

1. Which drug(s) are being prescribed for the member above throughout the course of treatment?
   Preferred: ☐ Follistim AQ ***Non-preferred:*** ☐ Bravelle ☐ Gonal-F
   ☐ Pregnyl ☐ Repronex ☐ Cetrotide ☐ hCG ☐ Menopur
   ☐ Leuprolide Acetate ☐ Novarel ☐ Ganirelix ☐ Ovidrel
   ☐ Other _____

2. What is the ICD code? _____

3. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If No, skip to #6

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

5. Is the medication effective in treating the member's condition? ☐ Yes ☐ No Continue to #6 and complete this form in its entirety

Complete the following questions if Bravelle and/or Gonal-F are being prescribed.

6. Is the physician willing to switch to the preferred product, Follistim AQ? ☐ Yes ☐ No

7. Has the patient received treatment with either Bravelle or Gonal-F product within the last 120 days? ☐ Yes ☐ No
   If Yes, continue to next section.

8. Does the patient have a contraindication to Follistim AQ or any of its drug components? ☐ Yes ☐ No
   If Yes, continue to next section.

9. Is the patient intolerant to or had confirmed adverse event with Follistim AQ? ☐ Yes ☐ No
   If Yes, continue to next section.

Complete the following section based on the patient's gender.

<u>Section A: Female Patient</u>

10. What is the diagnosis? ☐ Infertility ☐ Other _____

11. Indicate therapy status: □ New therapy □ Continuation of therapy

12. Indicate prior treatment cycles:
    # Previous Bravelle cycles (IUI of IVF): _____

    # Previous Gonal-F cycles (IUI of IVF): _____

    # Previous Follistim AQ cycles (IUI of IVF): _____

13. Indicate current treatment plan: □ IUI □ IVF □ FET □ Stimulation/Times Relations

14. Provide procedure authorization number and dates.
    Number MUST be obtained from CareFirst Medical Management Dept. prior to submission of this prior authorization request.

    AUTH# _____ Approval Date: _____/_____/_____ to _____/_____/_____

Section B: Male Patient

15. What is the diagnosis?
    □ Prepubertal cryptorchidism □ Testicular hypogonadism
    □ Hypogonadotropic hypogonadism □ Other _____

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)**