PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Follistim AQ® Prior Authorization Request Form (Page 1 of 2)

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:
❑ 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): _____

For all diagnoses, answer the following:
Is this medication prescribed by or in consultation with a reproductive endocrinologist? ❑ **Yes** ❑ **No**
Does the patient have history of trial, failure, or contraindication to Gonal-f/Gonal-f RFF (follitropin alfa)? ❑ **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**

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Follistim AQ® Prior Authorization Request Form (Page 2 of 2)

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: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	