

Menopur® 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:
<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"/> Controlled ovarian hyperstimulation <input type="checkbox"/> Male hypogonadotropic hypogonadism <input type="checkbox"/> Ovulation induction <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Prescriber's Specialty: Is this medication prescribed by or in consultation with a reproductive endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For controlled ovarian hyperstimulation, answer the following: Does the patient have a diagnosis of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For male hypogonadotropic hypogonadism, answer the following: Select the diagnosis: <input type="checkbox"/> Male primary hypogonadotropic hypogonadism <input type="checkbox"/> Male secondary hypogonadotropic hypogonadism Is this medication being used for induction of spermatogenesis? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the infertility due to primary testicular failure? <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 Is this medication being used for the induction of ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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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:				
1 st Attempt		2 nd Attempt		Letter Mailed: