PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Is Leuprolide acetate or Lupron Depot being prescribed for this member?
   - Yes - Leuprolide acetate ☐
   - Yes - Lupron Depot ☐
   - No ☐

2. What is the type of procedure the patient will be undergoing?
   - 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]) ☐
   - Other, please specify. ☐

   _____

3. What is the intent of therapy?
   - Inhibition of premature luteinizing hormone (LH) surge ☐
   - Trigger of oocyte maturation and ovulation ☐
   - Other, please specify. ☐

   _____

4. Leuprolide acetate or Lupron Depot does not meet guidelines. See comments for instructions.
   - Review more infertility medications ☐
   - Infertility review complete ☐

   If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

5. Leuprolide acetate will be approved for 12 months.
   - Review more infertility medications ☐
   - Infertility review complete ☐

6. Is cetrorelix acetate, Cetrotide, Fyremadel and/or Ganirelix being prescribed for this member? **Y** ☐ **N** ☐

7. What is the type of procedure the patient will be undergoing?
   - 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]) ☐
   - Other, please specify. ☐

   _____

8. What is the intent of therapy?
   - Inhibition of premature luteinizing hormone (LH) surge ☐
   - Other, please specify. ☐

   _____

9. Cetrorelix acetate, Cetrotide, Fyremadel, and/or Ganirelix will be approved for 12 months.
   - Review more infertility medications. ☐
   - Infertility review complete ☐

10. Cetrorelix acetate, Cetrotide, Fyremadel, and/or Ganirelix does not meet guidelines. See comments for instructions.
   - Review more infertility medications. ☐
   - Infertility review complete ☐
   - If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

11. Are hCG, Novarel, Ovidrel and/or Pregnyl being prescribed for this member? **Y** ☐ **N** ☐

12. What is the patient's diagnosis or the type of procedure the patient will be undergoing?
   - 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]) ☐
   - Prepubertal cryptorchidism ☐
   - Hypogonadotropic hypogonadism ☐
   - Other, please specify. ☐

   _____

13. Does the patient have a low pretreatment testosterone level? ACTION REQUIRED: If Yes, attach laboratory results of testosterone level. **Y** ☐ **N** ☐

14. Does the patient have low or low to normal levels of follicle stimulating hormone (FSH) or luteinizing hormone (LH)? ACTION REQUIRED: Attach laboratory results of FSH or LH levels.
   - Yes - Follicle stimulating hormone (FSH) level ☐
   - Yes - Luteinizing hormone (LH) level ☐
   - No ☐

15. Novarel, Pregnyl, hCG and/or Ovidrel will be approved for 6 months.
   - Review more infertility medications ☐
   - Infertility review complete ☐

16. Novarel, Pregnyl, hCG and/or Ovidrel will be approved for 12 months.

Review more infertility medications ☐

Infertility review complete ☐

17. Novarel, Pregnyl, hCG, and Ovidrel do not meet guidelines. See comments for instructions.

Review more infertility medications ☐

Infertility review complete ☐

If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

18. Is Follistim AQ and/or Gonal-f being prescribed for this member? **Y** ☐ **N** ☐

19. What is the patient's diagnosis or the type of procedure the patient will be undergoing?

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]) ☐

Hypogonadotropic hypogonadism ☐

Other, please specify. ☐

_____

20. What is the patient's age?

Less than 37 years of age ☐

Greater than or equal to 37 years of age ☐

21. How many cycles of clomiphene citrate has the patient completed?

Less than 3 cycles ☐

Greater than or equal to 3 cycles ☐

22. Does the patient have a risk factor for poor ovarian response to clomiphene? **Y** ☐ **N** ☐

23. Does the patient have a contraindication or exclusion to therapy with clomiphene? **Y** ☐ **N** ☐

24. Does the patient have a low pretreatment testosterone level? ACTION REQUIRED: If Yes, attach laboratory results of testosterone level. **Y** ☐ **N** ☐

25. Does the patient have low or low to normal levels of follicle stimulating hormone (FSH) or luteinizing hormone (LH)? ACTION REQUIRED: Attach laboratory results of FSH or LH levels.

Yes - follicle stimulating hormone (FSH) level ☐

Yes - luteinizing hormone (LH) level ☐

No ☐

26. Gonal-F and/or Follistim AQ do not meet guidelines. See comments for instructions.

Review more infertility medications ☐

Infertility review complete ☐

If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

27. Gonal-F and/or Follistim AQ will be approved for 12 months.

Review more infertility medications ☐

Infertility review complete ☐

28. Is Menopur being prescribed for this member? **Y** ☐ **N** ☐

29. What is the type of procedure the patient will be undergoing?

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]) ☐

Other, please specify. ☐

_____

30. What is the patient's age?

Less than 37 years of age ☐

Greater than or equal to 37 years of age ☐

31. How many cycles of clomiphene citrate has the patient completed?

Less than 3 cycles ☐

Greater than or equal to 3 cycles ☐

32. Does the patient have a risk factor for poor ovarian response to clomiphene? **Y** ☐ **N** ☐

33. Does the patient have a contraindication or exclusion to therapy with clomiphene? **Y** ☐ **N** ☐

34. Menopur does not meet guidelines. See comments for instructions.

Infertility review complete ☐

Infertility review complete ☐

If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

35. Menopur will be approved for 12 months.

Infertility review complete ☐

Infertility review complete ☐

36. Have any infertility medications been approved? If yes, load authorization for the indicated period of time for the approved drugs. **Y** ☐ **N** ☐

If one or more medications did not meet guidelines, remove the approved drug(s) from the drug name field. Pend initial PA to clinician by selecting Team Infertility Pend to Clinician. Open one new PA for all medications that did meet guidelines, attach any relevant documents, approve and load authorizations.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date