BlueCross BlueShield Federal Employee Program.

HUMAN CHORIONIC GONADOTROPIN PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Human Chorionic Gonadotropin (HCG) Powder

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is the patient assigned female or male at birth? ❑Female **OR** ❑Male
2. Is this request for HCG bulk powder for compounding and **NOT** for a commercially available product such as Novarel, Ovidrel or Pregnyl? ❑Yes ❑No
3. Which dosage form will the powder be compounded into? ❑Injectable ❑Oral ❑Topical
4. Why is the patient unable to use the commercially available product? ***Please select answer below:***
   ❑Intolerance to an inactive ingredient in the commercially available product
   ❑Other reason ***(please specify)***: _____
5. What dose/strength is being compounded? _____
6. **FEMALE Patient**: Please answer the following questions:
   a. Is the requested medication being used to treat infertility? ❑Yes ❑No
   b. Will the patient be undergoing an assisted reproductive technology (ART) procedure? ❑Yes***** ❑No
      ****If YES,*** please select the procedure being used below:
      - ❑Artificial insemination (AI)
      - ❑Embryo transfer and gamete intrafallopian transfer (GIFT)
      - ❑In vitro fertilization (IVF)
      - ❑Intracervical insemination (ICI)
      - ❑Fertility preservation/egg retrieval
      - ❑Intracytoplasmic sperm injection (ICSI)
      - ❑Intrauterine insemination (IUI)
      - ❑Intravaginal insemination (IVI)
      - ❑Zygote intrafallopian transfer (ZIFT)
      - ❑Frozen embryo transfer (FET)
      - ❑**Other *(please specify)***: _____

   c. Is this medication being used to treat sexual dysfunction? ❑Yes ❑No
7. **MALE Patient**: Please answer the following questions:
   a. What is the patient's diagnosis?
      - ❑Erectile or sexual dysfunction
      - ❑Hypogonadotropic hypogonadism (hypogonadism secondary to pituitary deficiency)
      - ❑Prepubertal cryptorchidism (failure of testicles to drop)
        i. Is the prepubertal cryptorchidism caused by an anatomic obstruction? ❑Yes ❑No
      - ❑None of the above

   b. Is this medication being used to treat erectile dysfunction (impotence) or sexual dysfunction? ❑Yes ❑No
8. Is this medication being used for weight loss, anti-aging effects, or performance (athletic) enhancement? ❑Yes ❑No
9. Is this medication being used for chronic pain management or neurogenesis? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. HCG – FEP MD Fax Form Revised 5/31/2024

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

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