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.

| **Member 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** | | | | | |

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

**Please select medication being prescribed:**

❑ **Novarel / Pregnyl (chorionic gonadotropin)** ❑ **Ovidrel (choriogonadotropin alfa)**

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

Is this request for brand or generic? ❑Brand ❑Generic

1. Is the patient assigned female or male at birth? ❑Female **OR** ❑Male

2. **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,*** which procedure will the patient be undergoing in combination with the requested medication(s)? ***Answer 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)***: _____

3. **MALE Patient:** Please answer the following questions:
   a. Will the patient need more than 18 vials every 84 days? ❑Yes* ❑No
      ***If YES***, please specify the requested quantity: _____ vials per 84 days
   b. What is the patient's diagnosis?
      - ❑Erectile or sexual dysfunction
      - ❑Hypogonadotropic hypogonadism (hypogonadism secondary to pituitary deficiency)
      - ❑Prepubertal cryptorchidism
        i. Is the prepubertal cryptorchidism caused by an anatomic obstruction? ❑Yes ❑No
      - ❑None of the above

4. Is this medication being used for weight loss, anti-aging effects, or performance (athletic) enhancement? ❑Yes ❑No

5. Is this medication being used for chronic pain management or neurogenesis? ❑Yes ❑No

6. Is this medication being used to treat erectile dysfunction (impotence) or sexual dysfunction? ❑Yes ❑No

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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.*** |