



Ticket #:	Request Date:	Request Time:

Cetrotide® Prior Authorization Request Form (Page 1 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required) **Provider Information** (required) Member Name: Provider Name: NPI#: Insurance ID#: Specialty: Date of Birth: Office Phone: Street Address: Office Fax: City: Office Street Address: State: Zip: 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: ■ Infertility ■ Other diagnosis: ICD-10 Code(s): **Clinical Information:** Select if the following exists: Unexplained infertility Endometriosis ■ Male factor infertility ■ Tubal factor infertility Any other indication for assisted reproductive technology (ART) (e.g., recurrent pregnancy loss, cervical or uterine factor infertility) Will Cetrotide be used for the development of multiple follicles (controlled ovarian hyperstimulation)?

Yes
No Will Cetrotide be used in conjunction only with assisted reproductive technology (ART)?

Yes No 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 that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Date:

Authorized Medical Signature:

Telephone:

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When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507 1-866-965-Drug (3784) / Fax # 866-999-7736

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