



Ticket #: Request Date: Request Time:			
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Gonal-f[®] & Gonal-f RFF[®] Prior Authorization Request Form (Page 1 of 2)

D	O NOT COPY FOR FUT	URE USE. FORMS ARE UP	DATED FREQUENTLY AN	ID MAY BE B	BARCODED	
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 Info	rmation (required)			
Medication Name:			Strength:		Dosage Form:	
☐ Check if requesting	brand		Directions for Use:			
☐ Check if request is for	or continuation of the	erapy				
		Clinical Inforn	nation (required)			
■ Controlled ovarian h ■ Male hypogonadotr ■ Ovulation induction ■ Other diagnosis: ■ Prescriber's Specialty	nyperstimulation opic hypogonadism		ICD-10 Code(s):			
		ation with a reproductive	endocrinologist? 🛭 Yes	□ No		
	a diagnosis of infertility g used for the develop	y? □ Yes □ No ment of multiple follicles (? □ Yes □ No) program? □ Yes □ No	
Select the diagnosis: Male primary hyp Male secondary h	ogonadotropic hypogo nypogonadotropic hypo g used for induction of	ogonadism spermatogenesis? 🗖 Ye				
For ovulation induction Does the patient have a list the infertility due to put its this medication being	on, answer the follow a diagnosis of anovula orimary ovarian failure g used for the inductio	ving: utory infertility? ☐ Yes ☐ ? ☐ Yes ☐ No n of ovulation? ☐ Yes ☐	□ No	information	the physician feels is important to	

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.

this review?

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Authorized Medical Signature:				
Telephone:	Date:			

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.