



Ticket #: Request Date: Request Time:	Request Time:	

Ovidrel® (chorionic gonadotropin) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE 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:	1	1	City: State: Zip:		Zip:			
Medication Information (required)								
Medication Name:			Strength:	Dosage Fo		orm:		
☐ Check if requesting	☐ Check if requesting brand			Directions for Use:				
☐ Check if request is for continuation of therapy								
Clinical Information (required)								
Select the diagnosis below: Hypogonadotropic hypogonadism Controlled ovarian hyperstimulation (development of multiple follicles) Ovulation induction Prepubertal cryptorchidism Other diagnosis: ICD-10 Code(s): For male hypogonadotropic hypogonadism, answer the following: Does the patient have male hypogonadism secondary to pituitary deficiency? Yes No Does the patient have low testosterone (below normal reference level provided by the physician's laboratory)? Yes No Does the patient have low LH (below normal reference level provided by the physician's laboratory)? Yes No Does the patient have low FSH (below normal reference level provided by the physician's laboratory)? Yes No Reauthorization: Is there documentation the patient has had a positive clinical response to therapy? Yes No								
For controlled ovarian hyperstimulation (development of multiple follicles), answer the following:								
Does the patient have a diagnosis of infertility? \(\begin{align*} \text{Yes} \text{No} \\ Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? \(\begin{align*} \text{Yes} \text{No} \\ \end{align*}								
	on, answer the followi		7.5		, , , , , , , , , , , , , , , , , , ,			
Does the patient have a diagnosis of anovulatory infertility? Yes No								
Is the infertility due to primary ovarian failure? \(\bar{\text{Ves}} \) \(\bar{\text{No}} \) Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? \(\bar{\text{Ves}} \) \(\bar{\text{No}} \)								
For prepubertal cryptorchidism, answer the following:								
Does the patient have a diagnosis of prepubertal cryptorchidism not due to anatomical obstruction? Yes No								
Are there any other comthis review?	ments, diagnoses, symp	toms, medications tried o	r failed, and/or any other	information	the physicia	n feels is important to		

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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.