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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Bravelle® 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:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Controlled ovarian hyperstimulation					
<input type="checkbox"/> Male hypogonadotropic hypogonadism					
<input type="checkbox"/> Ovulation induction					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Is this medication prescribed by or in consultation with a reproductive endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have history of trial, failure, or contraindication to Gonal-f/Gonal-f RFF (follitropin alfa)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For controlled ovarian hyperstimulation, also answer the following:					
Does the patient have a diagnosis of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For male hypogonadotropic hypogonadism, also answer the following:					
Select the diagnosis:					
<input type="checkbox"/> Male primary hypogonadotropic hypogonadism					
<input type="checkbox"/> Male secondary hypogonadotropic hypogonadism					
Is this medication being used for induction of spermatogenesis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the infertility due to primary testicular failure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For ovulation induction, also answer the following:					
Does the patient have a diagnosis of anovulatory infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the infertility due to primary ovarian failure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this medication being used for the induction of ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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. The information in this document is for the sole use of OptumRx. 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.**

Office use only: Bravelle_Comm_2018Feb-W