OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:
- ❑ Controlled ovarian hyperstimulation
- ❑ Male hypogonadotropic hypogonadism
- ❑ Ovulation induction
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
Is this medication prescribed by or in consultation with a reproductive endocrinologist? ❑ **Yes** ❑ **No**
Does the patient have history of trial, failure, or contraindication to Gonal-f/Gonal-f RFF (follitropin alfa)? ❑ **Yes** ❑ **No**

For controlled ovarian hyperstimulation, also answer the following:
Does the patient have a diagnosis of infertility? ❑ **Yes** ❑ **No**
Is this medication being used for the development of multiple follicles (controlled ovarian hyperstimulation)? ❑ **Yes** ❑ **No**
Is the medication for an ovulatory female patient participating in an assisted reproductive technology (ART) program? ❑ **Yes** ❑ **No**

For male hypogonadotropic hypogonadism, also answer the following:
Select the diagnosis:
- ❑ Male primary hypogonadotropic hypogonadism
- ❑ Male secondary hypogonadotropic hypogonadism

Is this medication being used for induction of spermatogenesis? ❑ **Yes** ❑ **No**
Is the infertility due to primary testicular failure? ❑ **Yes** ❑ **No**

For ovulation induction, also answer the following:
Does the patient have a diagnosis of anovulatory infertility? ❑ **Yes** ❑ **No**
Is the infertility due to primary ovarian failure? ❑ **Yes** ❑ **No**
Is this medication being used for the induction of ovulation? ❑ **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: 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.