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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

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:			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"/> Hypogonadotropic hypogonadism	
<input type="checkbox"/> Controlled ovarian hyperstimulation (development of multiple follicles)	
<input type="checkbox"/> Ovulation induction	
<input type="checkbox"/> Prepubertal cryptorchidism	
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____
For male hypogonadotropic hypogonadism, answer the following:	
Does the patient have male hypogonadism secondary to pituitary deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have low testosterone (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have low LH (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have low FSH (below normal reference level provided by the physician's laboratory)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For controlled ovarian hyperstimulation (development of multiple follicles), answer the following:	
Does the patient have a diagnosis of infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For ovulation induction, 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	
Has the patient been pre-treated with a follicular stimulating agent (e.g., gonadotropins, clomiphene citrate, letrozole)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For prepubertal cryptorchidism, answer the following:	
Does the patient have a diagnosis of prepubertal cryptorchidism not due to anatomical obstruction? <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: Ovidrel-chorionicgonadotropin_Comm_2017Jun-W