Fertility Agents (Injectable Gonadotropins Only)
Prior Authorization Request Form

JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Drug for which Prior Authorization is requested:

Follitropin alfa (Gonal-F®); Follitropin beta (Follistim®, Follistim AQ®); Urofollitropin (Fertinex®, Bravelle®); or Menotropins (Humegon®, Menopur®, Pergonal®, Repronex®)

Step 1

Please complete patient and physician information (Please Print)

Patient Name: ______________ Physician Name: ______________

Address: ______________ Address: ______________

______________ ______________

Sponsor ID # ______________ Phone #: ______________

Date of birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

	Yes	No
Is the fertility agent being prescribed for use in conjunction with a noncoital reproductive technology, including but not limited to artificial insemination, in vitro fertilization, or gamete intrafallopian transfer?	Coverage is not approved. The TRICARE family planning benefit outlined in the Code of Federal Regulations does not include services and supplies related to noncoital reproductive technologies.	Coverage is approved for 1 year. Coverage is limited to 3600 IU per 30 days with no refills.

Step 3

I certify the above is correct and accurate to the best of my knowledge.
Please sign and date:

______________________ Prescriber Signature

______________ Date

Latest revision: July 2009

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: