AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Infertility Drugs – Applicable for FEHB group members only

Drug Requested: select ALL drug(s) from below that are applicable to member's infertility drug regimen

❑ **cetrotide**	❑ **clomiphene citrate**	❑ **chorionic gonadotropin**
❑ **Crinone® gel**	❑ **Endometrin®**	❑ **First®-progesterone vaginal suppository**
❑ **Follistim® AQ**	❑ **Fyremadel**	❑ **ganirelix acetate**
❑ **Gonal-F®**	❑ **Gonal-F® RFF**	❑ **Menopur®**
❑ **Novarel®**	❑ **Ovidrel®**	❑ **Pregnyl®**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Provider please note: Members are limited to 3 complete treatment regimen cycles per year when prescribed for the treatment of infertility

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Provider must submit member's complete infertility drug protocol (including drug name, strength, dose & duration for prescribed therapies):

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

  Drug Name & Strength: _____ **Dose:** _____ **Duration:** _____

- ❑ Member is 18 years of age or older
- ❑ Member is using requested medication for infertility as defined by **ONE** of the following:
  - ❑ Members is unable to conceive or produce conception after one year of unprotected intercourse or therapeutic donor insemination
  - ❑ Member is older than 35 years of age and is unable to conceive or produce conception after six months of unprotected intercourse or therapeutic donor insemination
  - ❑ Member is unable to carry the fetus to term (e.g., three or more consecutive spontaneous miscarriages prior to 20 weeks gestational age)
- ❑ Member has **NOT** received more than 3 complete treatment cycles consisting of any drug regimen within the previous 365 days **(verified by chart notes and/or pharmacy paid claims)**

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 9/21/2023
REVISED/UPDATED: 11/6/2023