

Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Bravelle™ (Urofollitropin)
 BCBSVT and TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE:

YES NO

1. Patient will use therapy for Ovulation induction	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient will use agent in conjunction with human chorionic gonadotropin (hCG)	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient has previously received pituitary suppression	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient is ≥ 21 years of age	<input type="checkbox"/>	<input type="checkbox"/>
5. Prescriber is an Obstetrician/Gynecologist or Endocrinologist	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has tried two cycles of Clomid (Clomiphene Citrate)	<input type="checkbox"/>	<input type="checkbox"/>
7. Will Prescription be dispensed at (circle one): Provider Office Network Pharmacy		

REASONS FOR BENEFIT DENIAL

YES NO

1. Patient is pregnant or is lactating	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient has undiagnosed abnormal vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient has high levels of FSH indicating primary gonadal failure (ovarian)	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient has uncontrolled thyroid or adrenal function	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient has ovarian cysts or enlargement not due to polycystic ovary syndrome	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has organic intracranial lesion such as pituitary tumor	<input type="checkbox"/>	<input type="checkbox"/>
7. The cause of the patients infertility is not due to anovulation	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient has a prior hypersensitivity to urofollitropin, purified	<input type="checkbox"/>	<input type="checkbox"/>
9. This medication will be used for the purpose of or lead to -in vitro fertilization	<input type="checkbox"/>	<input type="checkbox"/>

If patient meets criteria: •**Approval:** 4 cycles (4 months) per 12 month period

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

