

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

If approval criteria are met Blue Cross and Blue Shield of Vermont/The Vermont Health Plan will authorize coverage of Fertinex® (Urofollitropin). Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 BCBSVT/TVHP Member ID#: _____ Date of birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____

INDICATIONS FOR USE:

	<u>YES</u>	<u>NO</u>
1. Patient will use therapy for ovulation induction	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients cause of infertility is functional (Not caused by primary ovulation failure)	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is ≥ 21 years of age	<input type="checkbox"/>	<input type="checkbox"/>
4. Prescriber is an Obstetrician/Gynecologist or Endocrinologist	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient has tried two cycles of Clomid (Clomiphene Citrate)	<input type="checkbox"/>	<input type="checkbox"/>
6. Will Prescription be dispensed at (circle one): Provider Office RESTAT Pharmacy		

REASONS FOR BENEFIT DENIAL:

	<u>YES</u>	<u>NO</u>
1. Patient is pregnant or 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 not had adequate trial of clomiphene citrate therapy	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient has sex hormone dependent tumors of the reproductive tract and accessory organs	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient is planning pregnancy via in vitro fertilization	<input type="checkbox"/>	<input type="checkbox"/>
9. Patient has already had a trial of an ovulation induction medication in the last 12 months.	<input type="checkbox"/>	<input type="checkbox"/>

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

PRESCRIBER SIGNATURE _____ DATE _____

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

