

**Blue Cross and Blue Shield of Vermont and The Vermont Health Plan  
Prior Approval Form  
GnRHa (Gonadotropin-releasing hormone agonists)  
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 GnRHa® (Gonadotropin-releasing hormone agonists). 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. <b>Patient has tried two cycles of Clomid (Clomiphene Citrate)</b>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Will Prescription be dispensed at (circle one):</b> <b>Provider Office</b> <b>RESTAT Pharmacy</b>		

**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 sex hormone dependent tumors of the reproductive tract and accessory organs	<input type="checkbox"/>	<input type="checkbox"/>
7. Patient has not had adequate trial of Clomiphene citrate therapy	<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**

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration of Therapy: \_\_\_\_\_

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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