

# Blue Cross and Blue Shield of Vermont and the Vermont Health Plan Prior Approval Form Gonal-F® (Follitropin alfa)

BCBSVT and TVHP Fax # (802) – 371-3491

If approval criteria are met Blue Cross and Blue Shield of Vermont/The Vermont Health Plan will authorize coverage of S Gonal-F® (Follitropin alfa). Thank you for your assistance.

**PLEASE COMPLETE THE FOLLOWING SECTIONS:**

Patient Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pt. Weight in kg: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INDICATIONS FOR USE:**

YES      NO

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 $\geq$ 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"/>

**REASONS FOR BENEFIT DENIAL:**

YES      NO

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"/>
Patient does not meet above criteria	<input type="checkbox"/>	<input type="checkbox"/>

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

*All information provided on this form is accurate as of this date.*

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date