Blue Cross and Blue Shield of Vermont and the Vermont Health Plan
Prior Authorization Form
Pergonal® (Follicle Stimulating Hormone and Luteinizing Hormone)
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 **Pergonal® (Follicle Stimulating Hormone and Luteinizing Hormone).** 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:

	YES	NO
1. Patient will use therapy for Ovulation induction	☐	☐
2. Patients cause of Infertility is functional (Not caused by primary ovarian failure)	☐	☐
3. Patient is ≥ 21 years of age	☐	☐
4. Prescriber is an Obstetrician/Gynecologist or Endocrinologist	☐	☐
5. **Patient has tried two cycles of Clomid (Clomiphene Citrate)**	☐	☐
6. **Will Prescription be dispensed at (circle one): Provider Office Restat Pharmacy**		

REASONS FOR BENEFIT DENIAL

	YES	NO
1. Patient is pregnant or is lactating	☐	☐
2. Patient has undiagnosed heavy or abnormal vaginal bleeding	☐	☐
3. Patient has primary ovarian failure	☐	☐
4. Patient has ovarian cysts or enlargement not due to polycystic ovary syndrome	☐	☐
5. Patient has uncontrolled thyroid or adrenal function	☐	☐
6. Patient has high levels of FSH indicating gonadal failure (Ovarian)	☐	☐
7. Patient has sex hormone dependent tumors of the reproductive tract and accessory organs	☐	☐
8. Patient has not had adequate trial of Clomiphene citrate therapy	☐	☐
9. Patient is planning pregnancy via in vitro fertilization	☐	☐
10. Patient has already had a trial of an ovulation induction medication in the last 12 months	☐	☐

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.

BlueCross BlueShield of Vermont
Independent Licensees of the Blue Cross and Blue Shield Association.