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LucyRx

Prior Authorization Request Form for Fertility Drugs

☐ Non-Urgent Request ☐ Urgent Circumstances (please include rationale Section IV)

This form is to be used by prescribers only.

I. Prescriber Information (please print)

Prescriber Name:	**Office Contact:**
Prescriber NPI:	**Phone:**
Specialty:	**Fax:**

II. Member Information (please print)

Member name:		**Phone:**	
Member ID #:	**Date of Birth:**	**Height:**	**Weight:**

Required to confirm address for any correspondence related to prior authorization(s)

Address:	**City:**	**State:**	**Zip:**

Medication allergies:

III. Drug Information (please identify (X) all therapies required for the protocol included in this request and fully complete the blank fields)

Drug name & Strength					Directions	Quantity	Days Supply
Ovulation Stimulants-Gonadotropins							
Ovidrel	☐	250 MCG/0.5ML					
Gonal-f	☐	300 UNIT/0.5ML	☐	450 IU MDV			
	☐	450 UNIT/0.75ML	☐	*Other:*			
Follistim AQ	☐	300 UNT cartridge	☐	900 UNT cartridge			
	☐	600 UNT cartridge	☐	*Other:*			
Menopur	☐	75 UNIT SQ soln, vial					
Chorionic Gonadotropin	☐	10,000 UNIT IM soln, vial	☐	*Other:*			
Other:							
GnRH/LHRH Antagonists							
Cetrotide	☐	0.25 MG SQ kit					
Ganirelix Acetate	☐	250 MCG/0.5ML SQ soln, prefilled syringe					
Other:							
LHRH Agonists							
Leuprolide Acetate	☐	1 MG/0.2 ML inj. kit	☐	*Other:*			
Other:							

IV. Diagnosis/Treatment/Protocol

Diagnosis:	**Treatment:**	**Protocol:**	**Start Date (if known):**

Prescriber/Agent Signature: **Date:**

Information on this form is Protected Health Information (PHI) and subject to all privacy and security under HIPAA.

Appropriate clinical information (including lab reports, when appropriate) to support the request on the basis of medical necessity must be submitted. LucyRx is unable to evaluate any request without office notes.