Fertility Medications

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication(s) requested *(please list all that apply)*:

	Medication 1	Medication 2	Medication 3	Medication 4	Medication 5
Name:					
Strength:					
Dosage:					
Quantity:					
Duration:					

Where will this medication be obtained?
☐ Accredo/Freedom Fertility Pharmacy**
☐ Retail pharmacy
** *Cigna's nationally preferred specialty pharmacy*
☐ Physician's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Is the patient undergoing covered treatment that may directly or indirectly cause iatrogenic infertility? ☐ Yes ☐ No

[for Cetrotide, Cetrorelix, Fyremadel, or Ganirelix requests ONLY]:

Is the requested drug being used for the inhibition of premature luteinizing hormone (LH) surges in a woman? Yes ☐ No ☐

Will the patient be undergoing controlled ovarian stimulation (COS) in conjunction with assisted reproductive procedures? Yes ☐ No ☐

What type of treatment is your patient undergoing?
☐ IUI
☐ IVF
☐ AI
☐ GIFT
☐ ZIFT
☐ Other

(if requesting brand Cetrotide) For the bioequivalent generic drug, cetrorelix acetate 0.25 mg injection, which of the following applies to your patient?
☐ Patient has not tried the bioequivalent generic drug.

☐ Patient tried the bioequivalent generic drug, but it didn't work or didn't work well enough.
☐ Patient tried the bioequivalent generic drug, but had an allergic or adverse reaction.
☐ Other

(if allergy) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the brand and bioequivalent generic products (for example, difference in dyes, fillers, preservatives)? Yes ☐ No ☐

(if yes) Please provide details to support.

[if Chorionic Gonadotropin, Novarel, Pregnyl]

What is the patient's diagnosis or reason for treatment?
☐ Ovulation induction in females undergoing infertility treatment
☐ Ovulation induction in females undergoing fertility preservation
☐ Males with documented hypogonadotropic hypogonadism
☐ Treatment of Prepubertal cryptorchidism
☐ Diagnostic testosterone stimulation test
☐ Obesity
☐ In combination with testosterone therapy
☐ Sexual dysfunction, including erectile dysfunction
☐ Treatment of low testosterone in the absence of hypogonadotropic hypogonadism
☐ Treatment of low testosterone due to hypogonadotropic hypogonadism concurrently with testosterone therapy
☐ Other

(if other) Please provide the patient's diagnosis or reason for treatment.

(if Diagnostic testosterone stimulation test) Is this medication to be used for evaluation of suspected hypogonadism? Yes ☐ No ☐

(if Diagnostic testosterone stimulation test) Is this medication prescribed by a provider who specializes in pediatric endocrinology or pediatric urology? Yes ☐ No ☐

(if Diagnostic testosterone stimulation test) Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New start
☐ Continuation of therapy

(if Continuation of therapy) Please provide support for continued use.

(if Treatment of Prepubertal cryptorchidism) Is the patient's diagnosis due to anatomical obstruction? Yes ☐ No ☐

(if Treatment of Prepubertal cryptorchidism) Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New start
☐ Continuation of therapy

(if Continuation of therapy) Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

(if no) Please provide support for continued use.

Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).

[for Gonal F, Menopur, Ovidrel only]

(if Gonal F, Menopur) What is the patient’s diagnosis or reason for treatment?
☐ Fertility preservation
☐ Infertility treatment
☐ Hypogonadotropic hypogonadism
☐ None the above/Other (please specify:

(if Ovidrel) What is the patient’s diagnosis or reason for treatment?
☐ Fertility preservation
☐ Infertility treatment
☐ None the above/Other (please specify:

(if fertility preservation or infertility treatment) Is the requested medication being used for ovulation induction? Yes ☐ No ☐

(if infertility treatment) What infertility service is your patient undergoing? (e.g. IUI, IVF, GIFT, ZIFT, etc.) Yes ☐ No ☐

(if hypogonadotropic hypogonadism) Does your patient have a documented diagnosis of hypogonadotropic hypogonadism? Yes ☐ No ☐

[if Follistim AQ]

What is the patient's diagnosis or reason for treatment?
☐ Fertility preservation
☐ Infertility treatment
☐ Hypogonadotropic hypogonadism
☐ None the above/Other (please specify:

(if fertility preservation/infertility treatment) Is the requested medication being used for ovulation induction? Yes ☐ No ☐

(if fertility preservation/infertility treatment) What infertility service is your patient undergoing? (e.g. IUI, IVF, GIFT, ZIFT, etc.)

(if hypogonadotropic hypogonadism) Does your patient have a documented diagnosis of hypogonadotropic hypogonadism? Yes ☐ No ☐

(if fertility preservation/infertility treatment) Has your patient started ovarian stimulation for the current fertility treatment? Yes ☐ No ☐

(if yes) Did your patient receive an injection of Follistim AQ today, yesterday, or the day before yesterday? Yes ☐ No ☐

(if no) What is the month and date of your last injection of Follistim AQ?

(if not started ovarian stim for current treatment OR has not received an injection of Follistim AQ today, yesterday, or the day before yesterday) Does your patient have a documented failure with Gonal-F? Yes ☐ No ☐

Please provide details about your patient's previous use of Gonal-F (including dates and results) and clinical rationale for Follistim AQ over the preferred brand, Gonal-F.

[if Leuprolide]

Is there documentation showing that the medication is being used for treatment of female infertility? Yes ☐ No ☐

(if no) What is the diagnosis related to use?

(if yes) What infertility service is your patient undergoing? (e.g. IUI, IVF, GIFT, ZIFT, etc.) Yes ☐ No ☐

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

NDC number is required on the medical claims to confirm claim is payable for the drug Pregnyl. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies >."

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