

US Family Health Plan Pharmacy Program Fertility Agents (Injectable Gonadotropins Only) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php

Drug for which Prior Authorization is requested:

Follitropin alfa (Gonal-F) ; Follitropin beta (Follistim , Follistim AQ) ; Urofollitropin (Fertinex , Bravelle) ; or Menotropins (Humegon, Menopur, Pergonal, Repronex)

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID: _____	Phone #: _____
Date of Birth: _____	Secure Fax: _____

Step 2

2 Please complete the clinical assessment:

Is the fertility agent being prescribed use in conjunction with a noncoital reproductive technology, including but not limited to artificial insemination, in vitro fertilization, or gamete intrafallopian transfer?	Yes Coverage is not approved. The TRICARE family planning benefit outlined in the Code of Federal Regulations does not include services and supplies related to noncoital reproductive technologies.	No Coverage is approved for 1 year. Coverage is limited to 3600 IU per 30 days with no refills.
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Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

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_____	_____
Prescriber Signature	Date