Gonal-F (follitropin alfa)

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Gonal-F HMSA - 01/2023.

CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819
Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com

Criteria Questions:

1. ***Indicate where the drug is being dispensed:***
   ❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
   ❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
   ❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
   ❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
   ❑ Psychiatric Facility ❑ Pharmacy ❑ Other

2. ***Indicate where the drug is being administered:***
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
   ❑ Office ❑ Outpatient Hospital ❑ Pharmacy

3. What is the ICD-10 code? _____

4. The preferred follitropin product for the member's plan is Follistim AQ. Can the member's treatment be switched to Follisitm AQ?
   ❑ Yes *If Yes, no further questions (Follistim AQ does not require prior authorization)* ❑ No

5. Does the member have a contraindication to Follistim AQ or any of its drug components? ***Action Required: If yes, please attach documentation that describes the contraindication.*** ❑ Yes *If Yes, skip to #7* ❑ No

6. Does the member have a history of intolerance or has the member had a confirmed adverse event with Follisitm AQ? ***Action Required: If yes, please attach documentation that describes the intolerance or adverse event.***
   ❑ Yes ❑ No

7. What is the prescribed dose of Gonal-f? _____

8. What is the diagnosis?
   ❑ Follicle stimulation as part of an in vitro fertilization (IVF) procedure
   ❑ Ovulation induction in conjunction with artificial insemination or timed intercourse *No further questions*
   ❑ Infertility in a male with hypogonadotropic hypogonadism *No further questions*
   ❑ Other_____ *No further questions*

9. Has the IVF procedure been approved by HMSA? ***Action Required: If yes, please attach a copy of the IVF approval form you received from HMSA.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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