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

What is your patient's diagnosis? ☐ Infertility ☐ Other (*please specify*): ICD10:

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

What is the estimated start date that your patient will need these medications?

[For Follistim AQ requests] For the current cycle, has your patient already begun treatment with Follistim AQ?
Yes ☐ No or Unknown ☐
(if yes) Did your patient receive an injection of Follistim AQ today, yesterday, or the day before yesterday?
Yes ☐ No or Unknown ☐
(if no) What is the month and date of your last injection of Follistim AQ?

Does your patient have a documented cycle failure with Gonal-F? Yes ☐ No or Unknown ☐
Please provide details about your patient's previous use of Gonal-F (including dates and results) and clinical rationale for Follistim AQ over Cigna's preferred brand, Gonal-F?

[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 ☐

(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.

[for HCG chorionic gonadotropin, Novarel or Pregnyl requests]

Will this drug be used in combination with ovulation stimulation therapy? Yes ☐ No ☐

(if anovulatory) Is the cause of anovulation secondary and not due to primary ovarian failure? Yes ☐ No ☐

[for Gonal F, Menopur, Ovidrel only]

Will the requested medication be used in combination with hCG (human chorionic gonadotropin) therapy? Yes ☐ No ☐

(if Menopur or Gonal F) Will the requested medication be used for ovulation stimulation? Yes ☐ No ☐

(if Ovidrel) Will the requested medication be used in combination with ovulation stimulation therapy in a woman? Yes ☐ No ☐

Will the requested medication be used in conjunction with an Assisted Reproductive Technology (ART) program? Yes ☐ No ☐

(If Gonal F) Is the medication being used for planned oocyte preservation? Yes ☐ No ☐

(If Gonal F) Which of these best describes the patient's infertility?

☐ Oligoovulatory (irregular or infrequent periods)
☐ Anovulatory (an egg is not released from the ovary during the menstrual cycle)
☐ Cause of infertility is not due to ovulatory dysfunction
☐ Unknown

(If Menopur or Ovidrel) Which of these best describes the patient's infertility?

☐ Oligoovulatory (irregular or infrequent periods)
☐ Anovulatory (an egg is not released from the ovary during the menstrual cycle)
☐ Other

Does the patient have primary ovarian failure? Yes ☐ No ☐

For male patients only:

What is the diagnosis or reason for use?

☐ cryptorchidism- (patient is prepubertal)
☐ cryptorchidism- (patient is post-pubertal)
☐ hypogonadotropic hypogonadism (hypogonadism or testicular hypofunction)
☐ diagnostic testosterone stimulation test
☐ other

(if cryptorchidism) Is your patient's cryptorchidism due to an anatomical obstruction? Yes ☐ No ☐

(if cryptorchidism) Is this new start of therapy with HCG or continuation of therapy? new start ☐ continuation of therapy ☐

(if continued therapy) Is there documentation your patient has had a beneficial clinical response with the requested medication? Yes ☐ No ☐

(if continued therapy) How many injections/weeks of therapy has your patient already received? Please include the dose and dates.

(if hypogonadism) Has your patient's diagnosis of HH been confirmed by laboratory testing? Yes ☐ No ☐
(if hypogonadism) Is HCG being used for the induction of spermatogenesis (fertility)? Yes ☐ No ☐

(if yes, spermatogenesis stim) Will this drug be used in combination with other agents for spermatogenesis stimulation? Yes ☐ No ☐

(if yes, spermatogenesis stim) What drugs will this product be used with for spermatogenesis stimulation?

☐ Follitropins
☐ Menotropins
☐ Other

(if other) Please specify:

(if yes, spermatogenesis stim) Does the patient have documented primary or secondary hypogonadotropic hypogonadism? Yes ☐ No ☐

(If diagnostic testosterone stim test) Has the patient received HCG previously for this use? Yes ☐ No ☐

(If diagnostic testosterone stim test) Has the prescriber evaluated the patient and has determined that the patient likely has hypogonadism? Yes ☐ No ☐

(if diagnostic testosterone stim test) Is this drug being prescribed by, or in consultation with, a provider who specializes in pediatric endocrinology or pediatric urology? Yes ☐ No ☐

Is HCG being given in combination with testosterone therapy? 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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