OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

*****Please Note: Infertility Treatment is a Group-Specific Benefit*****

Drug Requested ***(select from below)*:**

❑ **Novarel**® (chorionic gonadotropin)	❑ **Ovidrel**® (choriogonadotropin alfa)
❑ **Pregnyl**® (chorionic gonadotropin)	❑ **chorionic gonadotropin**

DRUG INFORMATION: ***Complete information below. Authorization process will be delayed if incomplete.***

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

CLINICAL CRITERIA*: *The following criteria MUST be met. ALL boxes must be checked to qualify or authorization process will be delayed. IF medical chart notes or lab results need to be submitted with this request, it needs to be stated here.

For 3 Month Approval for Ovulation Induction*: *All of the following criteria MUST be met and chart notes submitted for documentation:

- ❑ Patient has a diagnosis of anovulatory infertility **AND**
- ❑ Diagnosis of infertility is not due to primary ovarian failure **AND**
- ❑ Medication is being requested for induction of ovulation **AND**
- ❑ Patient has been pre-treated with a follicular stimulating agent (such as gonadotropin, clomiphene citrate or letrozole)

For 3 Month Approval for Controlled Ovarian Hyperstimulation*: *All of the following criteria MUST be met and chart notes submitted for documentation:

- ❑ Patient has a diagnosis of infertility **AND**
- ❑ Medication is being requested for the development of multiple follicles (controlled ovarian hyperstimulation) **AND**
- ❑ Patient has been or will be pre-treated with a follicular stimulating agent (such as gonadotropin, clomiphene citrate or letrozole)

For 2 Month Approval for Prepubertal Cryptorchidism*: *All of the following criteria MUST be met and chart notes submitted for documentation:

- ❑ Patient is between 4-9 years of age **AND**
- ❑ Patient has a diagnosis of prepubertal cryptorchidism ***NOT*** due to anatomical obstruction

For 6 Month Approval for Diagnosis of Hypogonadotropic Hypogonadism with Male Infertility - All of the following criteria MUST be met and chart notes submitted for documentation:

- ❑ Medication is being used for treatment of male infertility **AND**
- ❑ Prescriber is an endocrinologist **AND**
- ❑ Patient has a diagnosis of hypogonadism secondary to pituitary deficiency ***(MRI must be submitted for documentation)*** **AND**

(continued on next page)

- ❑ Infertility is ***NOT*** due to primary hypogonadism **AND**
- ❑ Labs performed within the last 12 months documenting all of the following must be submitted:
  - Low morning testosterone lab level collected between 6AM – 11AM ***(below normal reference level provided by the physician's lab)***
  - Low LH level ***(below normal reference level provided by the physician's lab)***
  - Low FSH level ***(below normal reference level provided by the physician's lab)***

For 6 Month Reauthorization for Diagnosis of Hypogonadotropic Hypogonadism with Male Infertility - All of the following criteria MUST be met and chart notes/labs submitted for documentation:

- ❑ Medication is being used for treatment of male infertility **AND**
- ❑ Prescriber is an endocrinologist **AND**
- ❑ Infertility is **NOT** due to primary hypogonadism **AND**
- ❑ Labs performed within the last 30 days documenting all of the following must be submitted:
  - Testosterone lab level collected between 6AM – 11AM is within normal limits of the reference levels provided by the physician's lab
  - LH level is within normal limits of the reference levels provided by the physician's lab
  - Low FSH level is within normal limits of the reference levels provided by the physician's lab

Medication being provided by a Specialty Pharmacy (check applicable box below):

For Optima Commercial Members:

- ❑ **PropriumRx**

For Family Care Members:

- ❑ **Sentara Norfolk General CM Pharmacy**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 4/19/2018
REVISED/UPDATED: 6/17/2018