Fertility Preservation Medications Prior Authorization Form

Maryland Medicaid Pharmacy Program

Fax#: (866) 440-9345 | Phone#: (800) 932- 3918

Incomplete forms will not be reviewed.

Date: _____

Patient's Information:

Name: _____ DOB: _____

Maryland Medicaid Number: _____ Sex: Cis Male ☐ Cis Female ☐

Allergies: _____ Weight: _____ Height: _____

Prescriber's Information:

Name: _____ Specialty: _____ NPI#: _____

Phone#: _____ Fax#: _____

Contact Person for this Request:

Name: _____ Phone#: _____

Diagnosis:

Diagnosis: _____ Diagnosis Date: _____

Requested Drug Information:

All medications will require a Preauthorization and includes the following:

- ☐ Pregnyl ® (chorionic gonadotropin)
- ☐ Ovidrel ® (choriogonadotropin alfa)
- ☐ Novarel ® (chorionic gonadotropin)
- ☐ Follistim AQ ® (follitropin beta)
- ☐ Gonal-f ® (follitropin alfa)
- ☐ Gonal-f-RFF ® (follitropin alfa/beta)
- ☐ Goanl-f-RFF Redi-Ject ® (follitropin alfa/beta)
- ☐ Ganirelix Acetate Injection
- ☐ Lupron ® (leuprolide acetate solution)
- ☐ Cetrotide ® (cetrorelix acetate)
- ☐ Menopur ® (menotropins)

☐ New Request ☐ Refill

Strength: _____ Quantity: _____

Directions: _____

Clinical Information:

Clinical documentation supporting the following must be submitted:

1. Patient has impairment of fertility due to:

   - ☐ Surgery
   - ☐ Radiation
   - ☐ Chemotherapy
   - ☐ Other medical treatment or intervention affecting reproductive organs or processes (explain below)

   _____

2. Age restrictions

   - ☐ Patient is within reproductive ages of puberty to menopause (except for ovarian tissue preservation)
   - ☐ Prepubertal age or insufficient time for oocyte retrieval for ovarian tissue cryopreservation

3. Initial Request Requirements:

   - ☐ Provider has attached clinical notes indicating treatment plan of the proposed fertility preservation services.
   - ☐ Provider attestation that all FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered.
   - ☐ Attestation of the discontinuation of all medications that are contraindicated in concurrent use.

4. Length of Authorization:

   Fertility Preservation procedures that require a preauthorization will be authorized for 3 months when criteria for initial approval are met.

   Cryopreservation of ovarian tissue and sperm would be a one- time benefit. A maximum of three cycles of ovarian stimulation and oocyte preservation will be covered.

   Please refer to clinical criteria for further details at: https://health.maryland.gov/mmcp/pap/pages/Clinical-Criteria.aspx

5. Additional Information:

   _____

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature.

Prescriber's Signature: _____ **Date:** _____