United Healthcare Community Plan

Fertility Preservation - Maryland
Prior Authorization Form

Please complete this **entire** form and fax it to **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.
Incomplete Forms will not be reviewed.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

☐ 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)	**Diagnosis:** _____ **Diagnosis Date:** _____
Strength:	**Quantity:**
Directions:	

Section E – Additional Information

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Member First Name:	Member Last Name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

Age Restriction (one of the following):

☐ Member 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

Member has impairment of fertility due to:

☐ Surgery

☐ Radiation

☐ Chemotherapy

☐ Other medical treatment or intervention affecting reproductive organs or processes:

_____

☐ Treatment plan and clinical notes attached to support request

☐ For cryopreservation of ovarian tissue and sperm, document cycles received: _____

_____

Prescriber Attestation:

☐ All FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered

☐ Discontinuation of all medications that are contraindicated in concurrent use

☐ Benefits of treatment for this individual outweigh the risks and the information provided on the form is true and accurate

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.

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

Provider Signature: _____ **Date:** _____