PARAMOUNT
Affiliate of ProMedica

CRITERIA: PMT
APPROVED: 05/2015
VERIFIED: 12/4/19
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Chorionic Gonadotropin (Paramount)

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Chorionic Gonadotropin (Paramount).

Drug Name (select from list of drugs shown)

Chorionic Gonadotropin- hCG	Novarel (chorionic gonadotropin-hCG)	Ovidrel (choriogonadotropin alfa, r-hCG)
Pregnyl (chorionic gonadotropin-hCG)		

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have ANY of the following exclusions to therapy with the requested agent? Y N

   Uncontrolled thyroid or adrenal dysfunction \ Uncontrolled organic intracranial lesion, such as a pituitary tumor \ Prostatic carcinoma or other androgen-dependent neoplasm (males only) \ Primary ovarian failure (females only) \ Sex hormone dependent tumors of the reproductive tract and accessory organs (females only) \ Abnormal uterine bleeding of undetermined origin (females only) \ Clinically significant ovarian cysts or enlargement of undetermined origin (females only) \ Pregnancy (females only)

   [If yes, no further questions.]
2. Is the patient a male with a diagnosis of hypogonadotropic hypogonadism? Y N

   [If yes, no further questions.]
3. Is the patient a male with a diagnosis of prepubertal cryptorchidism? Y N

[If yes, no further questions.]

4. Does this member have infertility coverage/rider? Y N
   [If no, no further questions.]
5. Is the drug being requested for a female patient as part of an ART program? Y N
   [If no, skip to question 7.]
6. Will the patient be pretreated with an appropriate follicle stimulating agent? Y N
   [If no, no further questions.]
   [If yes, skip to question 8.]
7. Is the drug being requested for a female as part of ovulation induction? Y N
   [If no, no further questions.]
8. Will therapy be continued during the luteal phase? Y N
   [If no, no further questions.]
9. Will therapy be withheld if there are risk factors or evidence of ovarian hyperstimulation syndrome (OHSS)? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date