

Infertility Therapy Enrollment Form



If you have questions or concerns, please call (866) 664-2673 x34628.
 Fax completed form to (866) 850-7806.

Patient Information				
Last Name		First Name		Middle
DOB (mm/dd/yy)				
Address		City	State	Zip
Daytime Phone		Evening Phone		Cell Phone
Insurance Information				
Policyholder's Name			Group #	
Name of Insurance Company			ID # on Insurance Card	
Physician Information				
Name		Specialty		Contact Name
Address			Phone Number	Secure Fax Number
Clinical Information				
Therapy Status:		Prior Treatment Cycles:		Current Treatment Plan:
<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuing Therapy		# Previous Bravelle Cycles (IUI or IVF):		<input type="checkbox"/> IUI <input type="checkbox"/> IVF <input type="checkbox"/> FET
Diagnosis (in words):		# Previous Gonal-f Cycles (IUI or IVF):		<input type="checkbox"/> Stimulation/Times Relations
Primary ICD-9 Code:		# Previous Follistim Cycles (IUI or IVF):		
Pharmacy Name		Phone		Fax
Procedure Authorization Number & Dates (Number MUST be obtained from CareFirst Medical Management Dept. prior to submission of this PA).				
AUTH #:		Approval Date: _____ to (mm/dd/yyyy) _____		
Prescription Information (PO Drugs do not need authorization, e.g. Clomid)				
Rx Name	Quantity	Rx Name	Quantity	
Bravelle 75 IU vial Sig.		HCG 10,000 IU vial Sig.		
Cetrotide 0.25mg kit Sig.		Ovidrel 250mcg Sig.		
Cetrotide 3mg kit Sig.		Lupron 2 wk kit Sig.		
Gonal-f 450 IU MDV Sig.		Lupron Microdose 50mcg/0.2ml 5ml vial Sig.		
Gonal-f 1050 IU MDV Sig.		Menopur 75IU vial Sig.		
Gonal-f 300 IU Pen Sig.		Repronex 75 IU vial Sig.		
Gonal-f 450 IU Pen Sig.		Progesterone in Oil 50mg/cc Sig.		
Gonal-f 900 IU Pen Sig.		Other Sig.		
Gonal-f 75 IU vial Sig.		Other Sig.		
Ganirelix 250mcg Sig.		Other Sig.		
Prescriber's Signature			Prescriber's Printed Name	
FOR USE BY PHARMACY MANAGEMENT DEPARTMENT				
<input type="checkbox"/> Approved <input type="checkbox"/> Benefit Exclusion <input type="checkbox"/> Pending Medical Precert Approval <input type="checkbox"/> Covered Under Medical Benefit <input type="checkbox"/> Denied <input type="checkbox"/> No Pharmacy Coverage through CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. <input type="checkbox"/> Denied by Medical Precert.				
Pharmacy Management Signature:				

IF APPROVED, AUTHORIZATION ONLY VALID FOR THIRTY (30) DAYS; YOU MUST REQUEST AUTHORIZATION FOR EACH REFILL.
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