



Infertility Drugs Prior Authorization Form

Instructions

- Please fill this form out completely.
- Fax or mail this form back to:

CDPHP
Pharmacy Department
500 Patroon Creek Blvd.
Albany, NY 12206-1057
Phone: (518) 641-3784
Fax: (518) 641-3208

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Patient ID Number: _____ Date of Birth: _____

Pharmacy and Phone (if known): Caremark Specialty Pharmacy Services 1-877-269-4831 or: _____

DRUG INFORMATION:

Drug Requested: _____ Strength: _____

Dosing Regimen: _____

CRITERIA:

1. Diagnosis? _____

2. Is this medication being used in conjunction with any of the following treatments?

IUI Yes No IVF Yes No ZIFT Yes No
TET Yes No GIFT Yes No

Other: _____

3. Prior treatment? Yes No

Drug(s): _____ Date(s): _____

Cycles used: _____ Outcome: _____

Please describe any additional medical rationale (if necessary): _____

PRACTITIONER INFORMATION:

Practitioner Name: _____ Practitioner Phone #: _____

Address: _____ Fax # (for fax notification): _____

Nurse Contact: _____ Ext: _____

Date of Request: _____