Fertility Agent Request Form

Fax this form and supporting chart notes to (503) 346-8351

Patient Information		
Last Name:	**First Name:**	
ID#:	**Date of Birth:**	
Prescriber Information		
Last Name:	**First Name:**	
NPI #:		
Phone #:	**Prescriber Fax #:**	
Address:		
City:	**State:**	**Zip:**
Medication Information		
Medication Name(s) with Strength:		
Requested Length of Therapy:		

Does the member meet one or more of the following conditions? Select all that apply.

Female:

- ☐ 35 years of age or younger with failure to conceive after regular unprotected sexual intercourse for 1 year or more
- ☐ 35 years of age or older with failure to conceive after regular unprotected sexual intercourse for 6 months or more
- ☐ Recurrent pregnancy loss defined as two or more pregnancy losses (miscarriages) prior to 20 weeks gestation
- ☐ Prior cycle of in vitro fertilization or intracytoplasmic sperm injection with failure
- ☐ Prior cycle of artificial insemination with the absence of an opposite-sex partner with failure
- ☐ Anticancer therapy induced ovulatory failure (e.g. alkylating agents)
- ☐ Impending infertility due to planned cancer therapy with curative intent (e.g., chemotherapy or oophorectomy)
- ☐ History of bilateral oophorectomy

Male

- ☐ Infertility due to cancer therapy (e.g., orchiectomy or chemotherapy)
- ☐ With non-obstructive azoospermia or severe oligospermia
- ☐ With paraplegia and sperm retrieval needed to achieve pregnancy
- ☐ HIV positive AND adherent with antiretroviral therapy AND washed sperm needed for insemination

I attest that the member is eligible for infertility treatment and that the information provided is true and accurate.

Prescriber Signature: _____ **Date:** _____

For questions, contact OHSU PBM Services at 1-833-247-6880