

PREAUTHORIZATION FORM
 Chorex, Novarel, Ovidrel, Pregnyl, Profasi
 (chorionic gonadotropin)

Therapeutic use: Exerts similar effects to luteinizing hormone, activating the production of gonadal steroid hormones to produce androgens and progesterone

Quantity Limit: Varies depending on product requested

Authorization Period: 12 months

Patient's name _____

Patient's ID# DOB / /

ICD-9

Physician's name _____

Physician's Ph# () - Fax# -

Physician's signature _____ Date signed / /

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Which drug is being requested? <input type="checkbox"/> Chorex <input type="checkbox"/> Novarel <input type="checkbox"/> Ovidrel <input type="checkbox"/> Pregnyl <input type="checkbox"/> Profasi		
2.	What is the medication being used for? <input type="checkbox"/> Hypogonadotropic hypogonadism <input type="checkbox"/> Cryptorchidism <input type="checkbox"/> Male oligospermia <input type="checkbox"/> Ovulation induction for infertility <input type="checkbox"/> Other: _____		
3.	If this patient is being treated for hypogonadotropic hypogonadism, has this patient failed testosterone replacement therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.