Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
(Antagon) Ganirelix acetate
BCBSVT and TVHP Fax # (888)–255-1006

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____

Member ID#:_____ Date of Birth: _____

Provider Name:_____ Provider Phone: _____

Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE:

	YES	NO
1. Patient will use therapy for Ovulation induction	☐	☐
2. Patients cause of Infertility is functional (Not caused by primary ovarian failure)	☐	☐
3. Patient is ≥ 21 years of age	☐	☐
4. Prescriber is an Obstetrician/Gynecologist or Endocrinologist	☐	☐
5. **Patient has tried two cycles of Clomid (Clomiphene Citrate)**	☐	☐
6. **Prescription be dispensed at (circle one): Provider Office Network Pharmacy**		

REASONS FOR BENEFIT DENIAL:

	YES	NO
1. Patient is pregnant or is lactating	☐	☐
2. Hypersensitivity to ganirelix acetate	☐	☐
3. Hypersensitivity to gonadotropin releasing hormone (GnRH) or any other GnRH analog	☐	☐
4. This medication will be used for the purpose of or lead to -in vitro fertilization	☐	☐

If patient meets criteria: •Approval: 4 cycles (4 months) per 12 month period

PRESCRIBER SIGNATURE_____ DATE_____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.