MEDICATION COVERAGE QUESTIONNAIRE

1. Please contact your insurance provider to obtain answers to the following questions.

2. Submit the completed questionnaire to the IVF Concierge Team at least 3 weeks before your start date.

IVF Concierge Team: **ivfsupport@mainlinefertility.com P: 484.380.4890 F: 484.380.5990**

Patient Name: _____

Patient DOB: _____ Estimated IVF Start Date: _____

Do I have prescription coverage for the following fertility medications?			**Are there dosage limitations?**	**Is prior authorization required?**	
Gonal-F	Yes	No	_____	Yes	No
Follistim	Yes	No	_____	Yes	No
Ganirelix	Yes	No	_____	Yes	No
Cetrotide	Yes	No	_____	Yes	No
Menopur/low does HCG	Yes	No	_____	Yes	No
HCG *(also called Novarel/Pregnyl/ Chorionic Gonadotropin)*	Yes	No	_____	Yes	No
Estrace 2mg	Yes	No	_____	Yes	No
Methylprednisolone	Yes	No	_____	Yes	No
Prednisone	Yes	No	_____	Yes	No
Progesterone in oil 50mg/ml	Yes	No	_____	Yes	No
Vivelle Dot 0.1mg Patch *(estrace patches)*	Yes	No	_____	Yes	No
400mg progesterone vaginal suppositories or Crinone 8% gel or Endometrin 100mg	Yes	No	_____	Yes	No
Neupogen 300mcg vial	Yes	No	_____	Yes	No
Lovenox 40mg	Yes	No	_____	Yes	No

Do I have a lifetime maximum for infertility medications? Yes No

If yes what is the amount? _____ Is it combined with my medical coverage? _____

Am I capitated to a specific pharmacy? Yes No

Pharmacy Name _____

Phone Number _____ Fax Number _____