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PRIOR AUTHORIZATION CRITERIA

BRAND NAME **SYNAREL**
(generic) **(nafarelin)**

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C8911-A***

CRITERIA FOR APPROVAL

1	Is the patient a male? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for a non-infertility indication? [If yes, then no further questions.]	Yes	No
3	Is the patient between 18 and 45 years of age? [If no, then no further questions.]	Yes	No
4	Is the requested drug being used in conjunction with any type of Artificial Reproductive Technology (ART) procedure [e.g., in Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or Intrauterine or Artificial Insemination]? [If yes, then no further questions.]	Yes	No
5	Has the prescriber performed an evaluation for other causes of infertility (e.g., prescriber has considered/ruled out hyperprolactinemia, thyroid dysfunction, premature or impending ovarian failure)? [If no, then no further questions.]	Yes	No
6	Has the prescriber evaluated the male partner for the presence of male factor infertility?	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 months	Go to 2
2.	Approve, 12 months	Go to 3
3.	Go to 4	Deny
4.	Deny	Go to 5
5.	Go to 6	Deny
6.	Approve, 12 months	Deny

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (NB)
Date Written: 05/2016
Revised:
Reviewed: Medical Affairs: (ME) 06/2016

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The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

Signature _____ Date _____

Client Name _____