

- New Request
- Update Existing Request
- Check here if URGENT

MTF providers may submit this form securely via the MTF Provider Portal: esrx.com/mpp

(Instructions available in Document Repository within the MTF Provider Portal)

Fax completed form to **1-866-684-4477**

Beneficiary Information			Date:
Beneficiary Name:	Sponsor SSN:		DOB:
Address:	City:	State:	Zip:
Beneficiary Phone:			

Location Information
Is the request from an MCSC, Non-GME MTF, or GME MTF? <input type="checkbox"/> MCSC – please complete Parts A & C <input type="checkbox"/> Non-GME MTF – please complete Parts A & C <input type="checkbox"/> GME MTF – please complete Parts B & C

Part A

Please check: <input type="checkbox"/> TriWest <input type="checkbox"/> Humana <input type="checkbox"/> MTF Requestor Name:			
Requestor Email:			
Requestor Phone:		Requestor Fax:	
Requestor acknowledges that the beneficiary is eligible for ART services and is seriously or severely ill (Category II, III) and has or will undergo cancer therapy that may have effected their fertility. Beneficiaries not meeting this requirement should undergo the normal prior authorization process. <input type="checkbox"/> Acknowledged			
Prescribing Physician Information			
Prescribing Physician Name:		Prescriber DEA/NPI (Required):	
Address:	City:	State:	Zip:
Prescribing Physician Phone:			
Is the prescribing physician also the physician deeming the beneficiary is eligible for fertility treatment under TOM Chapter 17, Sec 3. 2.5.2.10 Assisted Reproductive Technology (ART) Services. <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, please provide that physician's information below)			
Physician Name:		Prescriber DEA/NPI (Required):	
Address:	City:	State:	Zip:
Physician Phone:			

Proceed to Part C: Medication Information

Express Scripts

Part B

Part B GME MTF:			
Requestor Name:		Email:	
Requestor Phone:		Requestor Fax:	
Please check which GME MTF: <input type="checkbox"/> Walter Reed National Military Medical Center (WRNMMC) <input type="checkbox"/> Tripler Army Medical Center (TAMC) <input type="checkbox"/> Womack Army Medical Center (WAMC) <input type="checkbox"/> Madigan Army Medical Center (MAMC) <input type="checkbox"/> Brooke Army Medical Center (BAMC) <input type="checkbox"/> Naval Medical Center San Diego (NMCSO) <input type="checkbox"/> Naval Medical Center Portsmouth (NMCP) <input type="checkbox"/> Wright Patterson Medical Center/88th Medical Group (WPAFB)			
Prescribing Physician Information			
Prescribing Physician Name:		Prescriber DEA/NPI (Required):	
Address:	City	State:	Zip:
Prescribing Physician Phone:			

Proceed to Part C: Medication Information

Part C

Part C: Medication Information		
Medication Name(s):	Strength:	NDC:
Effective date:	Expiration Date:	
Directions:		