



Infertility Prior Authorization Form

Please fax completed form to CeltiCare Health Plan of Massachusetts, Inc., at (866)-614-1950

Patient Name: _____ **Date of Birth:** _____ **Member ID #** _____
Marital Status: Married _____ Single _____ **Spouse/Partner's name:** _____
Spouse/Partner's Sex: Male _____ Female _____
Prescribing Physician: _____ **Provider ID:** _____ **ART facility:** _____
Length of time trying to conceive (months/years) _____
Diagnosis/Reason for Treatment: _____
Pregnancy dates/outcome: _____

* Authorizations are valid up to one year (unless otherwise specified). All cycle starts (including FET & incomplete cycles) count as a cycle

A. General information for all Infertility Services (Please complete all that apply)	All Reviews require the following supporting documentation: FSH/CCCT results FSH/IUI flow charts, ART embryo flow charts, diagnostic study reports, patient history & physician treatment plan		
1. Requesting Gonadotropin:*	Preferred Gonadotropins: <input type="checkbox"/> Bravelle <input type="checkbox"/> Follistim AQ <input type="checkbox"/> Gonal-F <input type="checkbox"/> Gonal-F RFF <input type="checkbox"/> Menopur <input type="checkbox"/> Other (Please define) _____ * Prior authorization for Gonadotropins must be obtained from Caremark (Phone: 800-237-2767 or Prior Authorization Fax: 800-323-2445)		
2. Requesting procedure (check all that apply) :	<table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> FSH/IUI <input type="checkbox"/> IVF/GIFT < 40 <input type="checkbox"/> FSH no IUI <input type="checkbox"/> FET <input type="checkbox"/> ICSI </td> <td style="border: none; vertical-align: top;"> <input type="checkbox"/> IUI/Donor Sperm <input type="checkbox"/> Donor Egg <input type="checkbox"/> IVF/Donor Sperm <input type="checkbox"/> IVF ≥ 40 </td> </tr> </table>	<input type="checkbox"/> FSH/IUI <input type="checkbox"/> IVF/GIFT < 40 <input type="checkbox"/> FSH no IUI <input type="checkbox"/> FET <input type="checkbox"/> ICSI	<input type="checkbox"/> IUI/Donor Sperm <input type="checkbox"/> Donor Egg <input type="checkbox"/> IVF/Donor Sperm <input type="checkbox"/> IVF ≥ 40
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3. Number of past FSH/IUI cycles :	# of cycles initiated: _____		
4. Number of past ART cycles:	# of cycles initiated: _____		
5. Female < age 40 with a male partner unable to conceive for 12 menstrual cycles of exposure to sperm:	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No # of cycles trying to conceive: _____ (Provide medical rationale for exception)		
6. Female < 40 without a male partner has had exposure to sperm (IUI) for 6 cycles:	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No # of cycles trying to conceive: _____ (Provide medical rationale for exception)		
7. Female ≥ age 40 with a male partner unable to conceive for 6 menstrual cycles:	<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No # of cycles trying to conceive: _____ (Provide medical rationale for exception)		
8. History of voluntary sterilization of either partner: (if history of sterilization, please include details of corrective surgery and current tubal or semen status)	<input type="checkbox"/> No <input type="checkbox"/> Yes History of sterilization - male <input type="checkbox"/> Yes History of sterilization - female		

9. Rubella immune:	<input type="checkbox"/> Yes <input type="checkbox"/> No (If non immune, must be vaccinated and wait one month before seeking approval for ART) Date of immunization: _____
10. FSH and Estradiol annually on cycle day 3 for women <40:	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. CCCT test annually with day 3 FSH test repeated every 6 months for any woman >=40 years old:	<input type="checkbox"/> Yes Day 3 FSH E2 _____ Date _____ FSH day 10 ___ Date _____ <input type="checkbox"/> No FSH \geq 12 mIU/mL &/or E2 \geq 80 pg/mL for females \geq age 42 No FSH \geq 12 mIU/ml and/or E2 \geq 80 pg/ml for females \geq 42 Day 3 FSH E2 _____ Date _____ FSH day 10 _____ Date _____ *must provide copy of FSH/E2 lab results for all requests
12. Uterine cavity evaluation (HSG;HSC; or SHG) within the last year AND following any pregnancy that results in an antenatal, intrapartum or post partum complication:	<input type="checkbox"/> HSG Date : _____ <input type="checkbox"/> HSC Date: _____ <input type="checkbox"/> SHG Date: _____
13. Anesthesia consult prior to an IVF cycle for females with BMI \geq 35.	<input type="checkbox"/> BMI < 35 (N/A) <input type="checkbox"/> BMI \geq 35 (BMI _____ Date calculated _____) Date of anesthesia consult _____
14. Documentation of nutrition consult within 6 months and maternal fetal medicine consult for female with BMI \geq 40:	<input type="checkbox"/> BMI < 40 (N/A) <input type="checkbox"/> BMI \geq 40 (BMI _____ Date calculated _____) Date of nutrition consult _____
B. Information for all Gonadotropin/IUI coverage requests (check all that apply in addition to part A above)	
1. Has previously completed any ART cycles:	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Currently age \leq 39 with history of 0-3 prior FSH/IUI cycles (normal FSH and meets guidelines may authorize 3 FSH/IUI cycles/6 months)	<input type="checkbox"/> Yes # cycles _____ <input type="checkbox"/> No Has a history of > 3 FSH/IUI cycles
3. Currently age 30-39 with abnormal day 3 FSH \geq 15: failure of 1-2 cycles of IUI with gonadotropin stimulation required	<input type="checkbox"/> Yes # cycles _____ <input type="checkbox"/> No
4. Currently age 40-42, failure of 1-2 cycles of IUI with gonadotropin stimulation	<input type="checkbox"/> Yes # cycles _____ <input type="checkbox"/> No Has a history of > 1 FSH cycles (please include stimulated/IUI flow charts if patient has completed \geq 1 cycle)
C. Information for all ART coverage requests (check all that apply in addition to part A above)	
1. Currently < age 40	<input type="checkbox"/> 3-4 cycles FSH/IUI <input type="checkbox"/> <3 cycles FSH/IUI
2. Currently \geq age 40	<input type="checkbox"/> 1-2 cycles FSH/IUI <input type="checkbox"/> 0 cycles FSH/IUI
3. Total # of previous ART cycles	<input type="checkbox"/> 1-2 cycles <input type="checkbox"/> \geq 3 ART cycles (send summary of previous ART cycles)
4. Uterine Cavity evaluation: HSG, SHG or HSC (Repeated annually)	<input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No Please provide explanation: _____
5. Semen analysis > 10 mil Total Motile Sperm (TMS) (Completed within 1 yr)	<input type="checkbox"/> Yes Date : _____ <input type="checkbox"/> No (TMS) Results _____ Date _____ (If < 10 mil TMS provide SA results and urology consult notes)
6. TSH level < Age 35 Completed within 2 yrs \geq Age 35 Completed within 1 yr	<input type="checkbox"/> Normal Date: _____ <input type="checkbox"/> Abnormal Date: _____ Results _____