

Assisted Reproductive Technology (ART), Gonadotropin (FSH) and Intrauterine Insemination (IUI)

Patient name: _____ Date of birth: ____/____/____ Member ID # _____
 Partner name: _____ Date of birth: ____/____/____ Member ID # _____
 Prescribing Physician: _____ Provider ID: _____ ART facility _____
 Length of time trying to conceive (months/years) _____ Diagnosis/reason for treatment: Male Tubal/Endo Hormonal
 Unexplained Other Height _____ Weight _____ BMI* _____
 Pregnancy dates/outcome/Pregnancy _____

Authorizations are valid up to one year (unless otherwise specified) and all cycle starts (including incomplete cycles) count as a cycle
 * Tufts Health Plan will calculate BMI based on height and weight provided.

A. General information for all Infertility Services	All reviews require the following supporting documentation: FSH/CCCT results, FSH/IUI flow charts, ART embryo flow charts, semen analyses, THP Infertility Treatment Summary Form, diagnostic study reports, patient history and physician treatment plan.	
	Level 1 Review	Level 2 Review
1. Requesting Gonadotropin* *Please refer to Tufts Health Plan Infertility Medication Guidelines for preferred medication, dosing, etc.	Yes <input type="checkbox"/> No <input type="checkbox"/> Drug _____	Other _____ (please attach Universal Pharmacy form for any non-preferred infertility medication request)
2. Requesting procedure (check all that apply)	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"/> IIVF ≥ 40 <input type="checkbox"/>
3. Number of past FSH/IUI cycles	# of cycles initiated: _____	≥ 1 cycle <input type="checkbox"/>
4. Number of past ART cycles	# of cycles initiated: _____	≥ 6 cycles <input type="checkbox"/>
5. Female < age 35 with a male partner unable to conceive for 12 cycles (1 year)	N/A <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> # of cycles trying to conceive: _____ (Provide medical rationale for exception)
6. Female < age 35 without a male partner has had exposure to sperm (IUI) for 12 cycles (1 year)	N/A <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> # of cycles trying to conceive: _____ (Provide medical rationale for exception)
7. Female ≥ age 35 with a male partner unable to conceive for 6 cycles (6 months)	N/A <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> # of cycles trying to conceive: _____ (Provide medical rationale for exception)
8. Female ≥ age 35 without a male partner has had exposure to sperm (IUI) for 6 cycles (6 months)	N/A <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> # of cycles trying to conceive: _____ (Provide medical rationale for exception)
9. History of voluntary sterilization of either partner. (if history of sterilization must include details of corrective surgery and current tubal or semen status)	No <input type="checkbox"/>	Yes <input type="checkbox"/> History of sterilization – male Yes <input type="checkbox"/> History of sterilization - female
10. History of smoking within last 12 months	No <input type="checkbox"/>	Yes <input type="checkbox"/> Date stopped smoking _____ Provide cotinine level _____ Date _____
11. Rubella immune	Yes <input type="checkbox"/>	No <input type="checkbox"/> (needs to obtain Rubella immunity) Date of immunization: _____
12. FSH on day 3 & 10 is < 15 mIU/mL and Estradiol (E2) .80 pg/ml for females ≤ 41	Yes <input type="checkbox"/>	No <input type="checkbox"/> FSH ≥ 15 mIU/mL &/or E2 ≥ 80 pg/ml for females ≤ age 41
13. FSH on day 3 & 10 is < 12 mIU/mL and Estradiol (E2) .80 pg/mL for females ≥ age 42 (CCCT within 1 year & day 3 FSH within 6 month required on women ≥ age 40) * Must provide copy of FSH/E2 lab results for all requests	Yes <input type="checkbox"/> Day 3 FSH _____ E2 _____ Date _____ FSH day 10 _____ Date _____	No <input type="checkbox"/> FSH ≥ 12 mIU/mL &/or E2 ≥ 80 pg/mL for females ≥ age 42 FSH ≥ 12 mIU/ml and/or E2 ≥ 80 pg/ml for females ≥ 42 Day 3 FSH _____ E2 _____ Date _____ FSH day 10 _____ Date _____ *must provide copy of FSH/E2 lab results for all requests
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	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2. Currently <age 43 and meets guidelines may authorize up to 2 FSH/IUI cycles	Yes <input type="checkbox"/>	No <input type="checkbox"/> has a history of ≥ 2 FSH cycles
C. Information for all ART coverage requests (check all that apply in addition to part A above)		
1. Currently < age 40	____ cycles of FSH/IUI	<2 cycles FSH/IUI <input type="checkbox"/>
2. Currently ≥ age 40	____ cycles of FSH/IUI	
3. Total # of previous ART cycles	____ ART cycles	≥ 3 ART cycles (send summary of previous ART cycles)
4. Uterine Cavity evaluation: HSG, SHG or HSC (Repeated every two years)	Yes <input type="checkbox"/> Date _____	No <input type="checkbox"/> Please provide explanation
5. Semen analysis > 10 mil Total Motile Sperm (TMS) (Completed within 1 yr)	Yes <input type="checkbox"/> Date _____	No <input type="checkbox"/> (TMS) Results _____ Date _____ (If < 10 mil TMS provide SA results and urology consult notes)
6. TSH level < Age 35 Completed within 2 yrs ≥ Age 35 Completed within 1 yr	Normal <input type="checkbox"/> Date _____	Abnormal <input type="checkbox"/> Results _____ Date _____

Completed by: Signature _____ Date: _____
 (Printed name) _____ Phone # _____ Fax # _____

Fax completed form to Tufts Health Plan, Precertification Department at 617-972-9409
 Providers can call the Infertility Queue directly at 888-880-8699 x3405 or 617-923-5879