Female Infertility Injectable Medication Precertification Request

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

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About this form

Effective **January 1, 2020**, this form replaces all other Infertility Services precertification information request documents and forms. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Once completed, this form contains confidential information. Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-866-782-2779**.

How to fill out this form

As the patient's attending physician, you must complete Sections A through H of the form. Please complete this form **after precertification for treatment has been obtained**, when required by the plan.

Infertility Medications

Once you've obtained precertification for infertility treatment, if the member has pharmacy benefits for injectable medications through Aetna Specialty Pharmacy, complete the Female Infertility Injectable Medication Precertification Request Form. You can find the specialty pharmacy precertification form at **aetna.com/health-care-professionals/health-care-professional-forms.html**

You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- Send your clinical information by confidential fax to:
  - Precertification: 860-754-2515

- Mail your clinical information to: **PO Box 14079 Lexington, KY 40512-4079**

What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision.

How we make coverage determinations

The Clinical Policy Bulletins referenced will be used as a resource in decision making. We encourage you to review **Clinical Policy Bulletin #327: Infertility** before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?

If you have any questions about how to fill out the form or our precertification process, call us at:

- **800-575-5999** (TTY:711) and follow the prompts to connect with Aetna's Infertility Department.

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(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-782-2779
FAX: 1-860-754-2515

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Medical Endocrinologist** ☐ **Reproductive Endocrinologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Medication – Request is for:	Quantity	Dose/Frequency
☐ generic human chorionic gonadotropins (hCG) 10,000 unit vial		
☐ low dose hCG _____ *units per* _____ *mL*		
☐ Novarel or ☐ Pregnyl 10,000 unit vial		
☐ Ovidrel 250 mcg		
☐ ganirelix 250 mcg		
☐ Cetrotide ☐ 0.25 mg Kit		
☐ Menopur or ☐ Luveris		
☐ Lupron (call 1-855-240-0535 for precert review)		
☐ Zoladex (call 1-855-240-0535 for precert review)		
☐ Bravelle 75 IU vial		
☐ Gonal-F ☐ 450 IU vial		
☐ 1050 IU vial		
☐ Gonal-F RFF ☐ 75 IU vial		
☐ 300 IU vial or ☐ 300 IU redi-ject		
☐ 450 IU vial or ☐ 450 IU redi-ject		
☐ 900 IU vial or ☐ 900 IU redi-ject		
☐ Follistim AQ ☐ 75 IU vial		
☐ 150 IU cartridge		
☐ 300 IU cartridge		
☐ 600 IU cartridge		
☐ 900 IU cartridge		

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For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate type of cycle:

☐ Ovulation Induction (timed intercourse) ☐ Intrauterine Insemination (IUI) with gonadotropin medication ☐ Donor In-vitro fertilization (IVF)
☐ Non- donor (IVF) ☐ Frozen Embryo transfer cycle ☐ Gamete Intra-fallopian transfer (GIFT)
☐ In-vitro fertilization (IVF) ☐ Zygote Intra-fallopian transfer (ZIFT) ☐ Other: _____

For all requests: (Lab work must be submitted with request)

Please provide the un-medicated day 3 follicle stimulating hormone (FSH) measurement: _____ mIU/mL

Please provide the day 3 Estradiol level and date taken: _____ pg/mL Date _____/_____/_____

What date was the FSH measurement taken? (must be recorded within 6 months for a woman older than 35 years of age or in the prior 12 months for a woman 35 and younger): Date _____/_____/_____

☐ Yes ☐ No Is this request for cryopreservation of mature oocytes or embryos in women facing infertility due to chemotherapy, pelvic radiotherapy, or other gonadotoxic therapies?

☐ Yes ☐ No Has an approval of infertility treatment (non-drug services) been obtained for this cycle if required by the plan?
Authorization number: _____

☐ Yes ☐ No Has the patient been unable to conceive or reproduce conception after frequent, unprotected heterosexual intercourse?
→ **If yes**, please indicate the number of months of unsuccessful conception: _____

☐ Yes ☐ No Is the patient without a male partner who is unable to conceive or produce conception after cycles of donor insemination?
→ **If yes**, please indicate how many unsuccessful cycles of donor insemination the patient has received: _____ cycles

☐ Yes ☐ No Has either person (patient or partner) had a sterilization procedure in the past (with or without reversal)?

☐ Yes ☐ No Has the patient previously completed any ART cycles? ***If this is not the first cycle, please provide most current cycle sheet***
→ **If yes,** please indicate the type(s) of ART cycles there were previously completed: _____
How many cycles has the patient completed? _____ cycles
Please provide the dates of the completed ART cycles:
_____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____

For Follistim AQ:

☐ Yes ☐ No Does the patient have a documented failure of Gonal-F or Gonal- F RFF?
→ **If yes**, please provide the dates of the trial and failure: _____/_____/_____ , _____/_____/_____ , _____/_____/_____

☐ Yes ☐ No Does the patient have a contraindication, intolerance, or allergy to Gonal-F or Gonal- F RFF?

H. ACKNOWLEDGEMENT

The Aetna.com forms have an addition note after "Sign the Form". should that be added here?

Request Completed By *(Signature Required):* _____ **Date:** _____/_____/_____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.