aetna®

Male Infertility Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)
Please note that all authorizations are valid for 6 months only.

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

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
☐ human chorionic gonadotropins (hCG)	10,000 unit vial		
☐ Novarel or ☐ Pregnyl	10,000 unit vial		
☐ Menopur or ☐ Repronex	75 IU vial		
☐ Lupron (call 1-855-240-0535 for precert review)			
☐ Zoladex (call 1-855-240-0535 for precert review)			
☐ Luteinizing Hormone Releasing Hormone (LHRH)			
☐ Gonal-F	☐ 450 IU vial		
	☐ 1050 IU vial		
☐ Gonal-F RFF	☐ 75 IU vial		
	☐ 300 IU pen or ☐ 300 IU redi-ject		
	☐ 450 IU pen or ☐ 450 IU redi-ject		
	☐ 900 IU pen or ☐ 900 IU redi-ject		
☐ Follistim AQ	☐ 75 IU vial		
	☐ 150 IU cartridge		
	☐ 300 IU cartridge		
	☐ 600 IU cartridge		
	☐ 900 IU cartridge		

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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

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

☐ 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: _____

Please indicate the age of the female partner: _____

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

Please provide the most recent sperm analysis: Count _____ mL Clarity _____ Motility _____ % Date obtained _____/_____/_____

Please provide the patient's testosterone level and date obtained: _____ ng/dL Date obtained _____/_____/_____

Please provide the patient's FSH level and date obtained: _____ mIU/mL Date obtained _____/_____/_____

For human chorionic gonadotropins (hCG, Novarel, Pregnyl)

☐ Yes ☐ No Does the patient have a documented diagnosis of hypogonadotropic hypogonadism secondary to pituitary deficiency?

☐ Yes ☐ No Is the patient undergoing infertility treatment or actively trying to conceive a child?

For human menopausal gonadotropins (Menopur, Repronex)

☐ Yes ☐ No Is there clinical evidence of primary or secondary hypogonadotropic hypogonadism?

☐ Yes ☐ No Does the patient have primary testicular failure?

☐ Yes ☐ No Will the medication be used in combination with human chorionic gonadotropin (hCG) for the induction of spermatogenesis?

For Gonadotropin releasing hormones [(GNRH, Lupron, Zoladex), luteinizing hormone releasing hormone (LHRH)]

☐ Yes ☐ No Does the patient have documentation of infertility due to hypogonadotropic hypogonadism?

For Urofollitropins and recombinant follitropin products [(follitropin alfa (Gonal-F, Gonal- FRFF), follitropin beta (Follistim AQ)]

☐ Yes ☐ No Is there clinical evidence of primary or secondary hypogonadotropic hypogonadism?

☐ Yes ☐ No Does the patient have primary testicular failure?

☐ Yes ☐ No Will the medication be used in combination with human chorionic gonadotropin (hCG) for the induction of spermatogenesis?

For Follistim AQ:

☐ Yes ☐ No Does the patient have a documented failure of Gonal-F or Gonal- FRFF?
→ **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- FRFF?

H. ACKNOWLEDGEMENT

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.