Infertility Services
Precertification Information Request Form

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
You cannot use this form to initiate a precertification request. To initiate a request, call our Precertification Department or you can submit your request electronically.

This form will help you supply the right information with your precertification request. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage**.

How to fill out this form
As the patient's attending physician, you must complete all sections of the form. Please complete this form at least 15 days prior to the planned treatment start date. 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.

Infertility Medications
Once you've obtained precertification for infertility treatment, if the member has pharmacy benefits for injectable medications through Aetna, 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**

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

- We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. **Register today at availity.com/aetnaproviders or learn more about Availity at www.availity.com/aetnatraining.**
- Precertification- Commercial and Medicare using **FaxHub: 1-833-596-0339**
  - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims etc.) to appropriate fax numbers. Thank you.
- Mail your clinical information to: **PO Box 14079**
  Lexington, KY 40512-4079

What happens next?
Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

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** and **Clinical Policy Bulletin #358: Invasive Prenatal Diagnosis of Genetic Diseases,** 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. Prior treatment approval does not guarantee approval for ongoing or future treatment.

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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Section 1: Provide the following general information	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:** / /
Member preferred contact number ( ) -	
Member assigned gender at birth: ☐ Female ☐ Male	**Member identified gender:** ☐ Female ☐ Male ☐ Non-Binary
Requesting Provider and/or group name:	**Provider or group Address:**
Provider or group TIN:	**Provider or group fax number:**
Contact name of office personnel to call with questions:	**Telephone number (with extension):** - - ext.

Section 2: Treatment Plan

Requested service:

- ☐ Intrauterine Insemination (IUI) Medication used: _____
- ☐ Pre-Implantation Genetic Screening (PGT-A/PGS)
- ☐ Pre-Implantation Genetic Diagnosis (PGT-M, PGT-SR) **Please submit genetic testing results with this request for both male and female (when applicable)**
- ☐ Cryopreservation
- ☐ Thawing ☐ Storage
- ☐ Social Fertility Preservation ☐ Iatrogenic Fertility Preservation
- ☐ Complete In Vitro Fertilization (IVF)
- ☐ In Vitro Fertilization (IVF) Freeze All
- ☐ Assisted Hatching (AH)
- ☐ Intra-cytoplasmic Sperm Injection (ICSI)
- ☐ Frozen Embryo Transfer (FET)
- ☐ Egg/Thaw/Fert/No Transfer
- ☐ Other (please specify) _____

Planned start date of current treatment cycle requested: / /	**Donor sperm:** ☐ Yes ☐ No **Donor eggs:** ☐ Yes ☐ No **Donor embryo:** ☐ Yes ☐ No

Section 3: Member's Clinical History

Cycle Day 3 Bloodwork

FSH Level: **E2 level:**

Date of last menstrual period (LMP) with Day 3 bloodwork: / /

Date collected (must be drawn within the past 6 months): / /

Has member taken any estrogen (including birth control) within the last 30 days? ☐ Yes ☐ No

If yes, list medication(s):

Does the member currently have a partner? ☐ Yes ☐ No	**Is the partner:** ☐ **Male** ☐ **Female** **Partner's Full Name:** _____
Is the member currently trying to conceive with their current partner? ☐ Yes ☐ No	**If yes, how long with this partner?** _____

Member name:	
Reference number:	**Member ID:**

Section 3: Member's Clinical History, continued

Is there a history of sterilization for the member? ☐ Yes ☐ No	**If yes, has a reversal been completed?** ☐ Yes ☐ No
Is there a history of sterilization for the partner? ☐ Yes ☐ No	**If yes, has a reversal been completed?** ☐ Yes ☐ No

Does the member have regular cycles: ☐ Yes ☐ No **If not, how many cycles per year?** _____

Previous pregnancy history/outcome:

Never been pregnant: ☐

Month/year of pregnancy (Please include if infertility therapy was used/was there a fetal heartbeat confirmed (if loss)/gestational age at time of loss or birth): _____

Section 4: Provide ONLY the following documentation for your request

- **First treatment request with Aetna and/or last treatment request was over one year ago:**

☐ Time trying to conceive OR medical history which led to diagnosis of infertility
☐ History of sterilizations
☐ Cycle Day 3 bloodwork
☐ **If prior request was over a year ago:**
  ☐ Is the member still with the same partner (if applicable)
  ☐ Have there been any history of sterilizations since last treatment

- **OI, IUI, and timed intercourse cycles**:

☐ Medication to be used (if any)
☐ Time trying to conceive OR Medical history which led to diagnosis of infertility
☐ All previous IUI cycles (if applicable)
☐ History of sterilizations
☐ Cycle Day 3 bloodwork

- **Initial ART Cycle:**

☐ Indication for advanced reproductive technology (ART) treatment request
☐ Time trying to conceive OR Medical history which led to diagnosis of infertility
☐ All previous IUI cycles (if applicable)
☐ History of sterilizations
☐ Cycle Day 3 bloodwork

- **Additional ART cycle requests:**

☐ Cycle Day 3 bloodwork
☐ Complete #5 in Section 5 for previous ART cycles including embryology report

- **PGT-M or PGT-SR:**

☐ Genetic testing reports for member and partner (when applicable)
☐ Karyotype report if requesting PGT-SR for member and partner (when applicable)

Member name:	
Reference number:	**Member ID:**

Section 5: Advanced Reproductive Technology (ART) Requests

1. Completion of previous ovulation induction (OI) cycles: Please Note: Only include the below treatments that were done by the member you are currently requesting treatment for or indicate clearly if the partner was the one completing the below: Only include the medication information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the medication.:

Cycle #	Medication taken for OI Cycle	Month/Year Completed/Outcome	IUI or Timed Intercourse
1			
2			
3			

2. Endometriosis or pelvic surgeries: Submit the operative report. Include stage of endometriosis (if appliable).

3. Tubal factor: A hysterosalpingogram (HSG) is required. Submit the HSG with dye report. Do not include Sono HSG or Femvue.
History of ectopic pregnancy during infertility treatment: ☐ Yes ☐ No

4. Male factor: Submit two (2) abnormal semen analyses at least two (2) weeks apart for the request of ICSI. May include sperm prep reports.

5. Previous ART cycles: Fill in below for each ART cycle.

IVF: Only include the information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the treatment		
Retrieval date: / /	Retrieval date: / /	Retrieval date: / /
# of oocytes retrieved:	# of oocytes retrieved:	# of oocytes retrieved:
# of oocytes with conventional insemination:	# of oocytes with conventional insemination:	# of oocytes with conventional insemination:
# of oocytes with ICSI:	# of oocytes with ICSI:	# of oocytes with ICSI:
# of oocytes fertilized:	# of oocytes fertilized:	# of oocytes fertilized:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos cryopreserved:	# of embryos cryopreserved:	# of embryos cryopreserved:
# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:
Results of PGD/PGS:	Results of PGD/PGS:	Results of PGD/PGS:

Member name:	
Reference number:	**Member ID:**

Continued: **Previous ART cycles: Fill in below for each ART cycle.**		
FET: Only include the information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the treatment		
Transfer date: / /	Transfer date: / /	Transfer date: / /
# of embryos thawed:	# of embryos thawed:	# of embryos thawed:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos still frozen:	# of embryos still frozen:	# of embryos still frozen:

Section 6: Read this important information

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.

Section 7: Sign the form

Just remember: You can't use this form to initiate a precertification request.

To initiate a request, submit it electronically or you can call our Precertification Department.

Signature of person completing form:

Today's date: / /