aetna®

Female 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
☐ 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 ☐ Repronex 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		

Continued on next page

aetna®

Female Infertility Injectable Medication Precertification Request

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

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

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 the patient enrolled with Aetna's Infertility Program (1-800-575-5999) for approval of medical (non-drug) services for this cycle?

☐ 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- 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?

☐ Yes ☐ No Does the patient have a documented failure of Bravelle?
→ **If yes**, please provide the dates of the trial and failure: ____/____/____ , ____/____/____ , ____/____/____

☐ Yes ☐ No Does the patient have a contraindication, intolerance, or allergy to Bravelle?

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.