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)

Infertility Services
Precertification Information Request Form

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 ( ) -	
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:

- ☐ Injectable Timed Intercourse Medication used:
- ☐ Intrauterine Insemination (IUI) Medication used:
- ☐ Pre-Implantation Genetic Screening (PGT-A/PGS/PGT-SR)
- ☐ Pre-Implantation Genetic Diagnosis (PGD) **Please submit genetic testing results with this request**
- ☐ 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)

Start date of cycle: / /	**Donor sperm:** ☐ Yes ☐ No **Donor eggs:** ☐ Yes ☐ No

Date of last menstrual period (LMP): / /

Does the member have regular cycles: ☐ Yes ☐ No

If not, how many cycles per year? _____

Section 3: Member's Clinical History

Day 3 Bloodwork (to be drawn unmedicated; not while taking or after stopping any estrogen within 30 days)

FSH Level: **E2 level:**

Date collected: / /

Was member on medication(s) when blood work was drawn? ☐ 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? ☐ Yes ☐ No	**If yes, how long with this partner?** _____
Is there a history of sterilization for the member? ☐ Yes ☐ No	**If yes, has a reversal been completed?** ☐ Yes ☐ No

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

Section 3: Member's Clinical History, continued

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

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

- **OI, IUI, and timed intercourse cycles**: Medication to be used (if any), and day three (3) blood work
- **Initial ART Cycle:** Submit indication for IVF/FET (i.e., severe male factor, tubal factor, previous ovulation induction cycles without pregnancy, stage III or IV endometriosis)
- **Additional ART cycle requests:** Day three (3) bloodwork, and complete #5 below in Section 5 for previous ART cycles including embryology report

Section 5: Advanced Reproductive Technology (ART) Requests

1. **Completion of previous ovulation induction (OI) cycles:** Please do not send cycle sheets unless specifically requested.

Cycle #	Medication taken for OI Cycle	Month/Year Completed/Outcome
1		
2		
3		

2. **Endometriosis or pelvic surgeries:** Submit the operative report

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. May include sperm prep reports.

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

IVF		
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		
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: / /