Infertility Services

Prior Authorization Request Form

Requested Services:	MD Name:	
Facility:	Tax Identification Number (TIN):	NPI:

Patient

Name:

Member ID #:	**DOB:**	**TSH:**	**Rubella:**
Infertility diagnosis:	**How long attempting to conceive?**		
Hx: voluntary sterilization and reversal (yes/no) <Select>	**If yes, include dates:**		

Tests/ Procedures

Completed within the past 24 months, confirming presence of ALL the following:

1. **At least one normal and patent Fallopian tube.**
2. **Normal ipsilateral ovary.**
3. **Normal endometrial cavity.**

Test	**Date Completed**	**Results**
☐ HSG ☐ Laparoscopy ☐ Sonohyst ☐ Office HSC ☐ FemVue		

☐ **Age < 40**		☐ **Age 40+**	
Dav 3 FSH/E2 results within 12 months		**CCCT w/i past 6 months, and** **If CCCT > 6 months ago then also submit Day 3 FSH/E2 done within 6 months.**	
Date Completed	**Results**	**Date Completed**	**Results**
	Day 3 FSH: **Day 3 E2:**		**CCCT:** **Day 3 FSH:** **Day 3 E2:** **Day 10 FSH:** **Updated Day 3 FSH:** **Day 3 E2:**

Partner

Name:

Member ID #:	**DOB:**
Infertility diagnosis:	**How long attempting to conceive?**
Hx: voluntary sterilization and reversal (yes/no) <Select>	**If yes, include dates:**

Semen Analysis

One required within 12 months of the requested service, or two performed at least two weeks apart if the first result is abnormal.
If the second is abnormal a urology consult is required.

Date(s) Completed	**Volume (cc):**	
	Concentration (mil/cc):	**Motility (%):**
	Number (million):	**Morphology (%):**

✉ Fax the following documentation along with completed form to 508-756-1382:

- **Infertility MD Evaluation:** History and Physical and most recent clinical note.
- **Consultation (e.g., urology, genetics):** Clinical notes including any follow up and testing.

HPI reserves the right to request additional clinical information.

Submission of IUI and IVF Cycle Results

- **IUI Cycles:** Please submit results on the IUI Summary Sheet (attached)
- **IVF Cycles:** Please submit results on the IVF Summary Sheet (attached)

Completed by: *(Please print)*

Name: Fax:

Phone: Date:

IUI Cycle Summary

Patient's last name:	Patient's first name:	Patient's date of birth:	Member ID #:
Partner's last name:	Partner's first name:	MD of record:	Member ID #:

Start date	Stim medication type/dose	Cycle day of ovulation	Peak E2	# of follicles >12 mm for FSH stimulation	Total Motile Sperm (TMS)/morphology pre and post wash	Donor Sperm Y/N	Outcome

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IVF Cycle Summary

Patient's last name:	Patient's first name:	Patient's date of birth:	Member ID #:
Partner's last name:	Partner's first name:	MD of record:	Member ID #:

	#	Start date	Procedure	Peak E2	# Eggs/ # mat	# Insem	Total motile sperm/morph	ICSI Y/N	# Ferts	# Trans	Embryo Quality	Cryo* # New/# Total	Outcome
1													
2													
3													
4													
5													

*Please record the number of new embryos frozen for each IVF cycle and the total number of embryos frozen including prior cycles. For frozen embryo transfers please record the number of thawed embryos as well as the number of embryos transferred and total frozen embryos remaining. *Note: Please use additional summary sheet if needed.*

*Procedure indicator #'s for above grid.			
10 = IVF attempted, no eggs retrieved biopsy	15 = IVF with EEJ sperm	51 = Gestational host with fresh embryo trans	0 = Oocyte donor
11 = IVF with partner's fresh sperm	16 = IVF attempted no sperm available	54 = Gestational host w/thaw embryo trans	4 = Thaw Cycle
12 = IVF with donor sperm	17 = IVF with sperm from test biopsy	60's sperm or oocyte source for Gest. host	18 = IVF with ICSI
13 = IVF with partner's frozen sperm	20's refer to Gift cycles	70 = cancelled cycle	19 = IVF/ICSI/PGT
14 = IVF with epid. Asp. Sperm	30's refer to Oocyte Recipient cycles	86 = cycle never really started	

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