TUFTS Health Plan

Infertility Authorization Form: Insemination Cycles (AI or IUI), Gonadotrophin (FSH) and Intrauterine Insemination (FSH/IUI), Assisted Reproductive Technology (ART)

Member Name:	Member DOB:	Member Age:	Member ID#:
Partner Name:	Partner DOB:	Partner Age:	Member ID#:
Prescribing Provider:	ART Facility Affiliation:		
Provider Name:	Provider ID#:		Provider Phone #:
Provider Fax #:	Provider Signature:		Date of Request:
Member's Diagnosis: ☐ Tubal/Endo ☐ Hormonal ☐ Male Factor ☐ Unexplained ☐ Other (please describe): _____			
Length of time trying to conceive:			
Pregnancy Dates/Pregnancy Outcomes:			
Member's Height:	Member's Weight:	Member's BMI*: (CALCULATED BY THP)	

Service(s) Requested _____

CPT/HCPCS Code(s)_____

- Please note: All reviews require the following supporting documentation: FSH/CCCT results, FSH/IUI flow charts, ART embryo flow charts, semen analyses, THP Infertility Treatment Summary Form, diagnostic study reports, including lab test results, patient history and physician treatment plan.
- Authorizations are valid for one year (unless otherwise specified) and all cycle starts (including incomplete cycles) count as a cycle.

A. General information for all Infertility Services	**Level 1 Review**	**Level 2 Review**
1. Requesting insemination cycle:	☐ AI ☐ IUI	
2. Requesting medication *Please refer to Tufts Health Plan Infertility Medication Guidelines for preferred medication, dosing, etc.	☐ Yes ☐ No Drug_____	Other _____ _____ (Attach Universal Pharmacy Programs Request form for any non-preferred infertility medication request)
3. Requesting procedure (check all that apply)	☐ FSH/IUI ☐ IVF/GIFT < 40 ☐ FET ☐ ICSI	☐ IUI / Donor Sperm ☐ IVF / Donor Sperm ☐ Donor Egg ☐ IIVF ≥ 40
4. Number of past FSH/IUI cycles	# of cycles initiated: _____	☐ ≥ 1 cycle
5. Number of past ART cycles	# of cycles initiated: _____	☐ ≥ 5 cycles
6. Female ≤ age 35 has had exposure to sperm for 12 cycles (1 year) and unable to conceive	☐ N/A ☐ Yes	☐ No **#** of cycles trying to conceive:_____ (Provide medical rationale for exception)
7. Female > age 35 has had exposure to sperm for 6 cycles (6 months) and unable to conceive	☐ N/A ☐ Yes	☐ No # of cycles trying to conceive:_____ (Provide medical rationale for exception)
8. History of voluntary sterilization of either partner. (if history of sterilization must include details of corrective surgery and current tubal or semen status)	☐ No	☐ Yes History of sterilization – male: Date corrected_____ ☐ Yes History of sterilization – female: Date corrected_____
9. History of smoking within last 12 months	☐ No	☐ Yes Date stopped smoking _____ Provide cotinine level _____ Date _____

A. General information for all Infertility Services	Level 1 Review	Level 2 Review
10. Rubella immune	☐ Yes	☐ No (needs to obtain Rubella immunity) Date of immunization: _____
11. FSH on day 3 is < 15 mIU/mL and Estradiol (E2), 80 pg/ml for females ≤ 41	☐ Yes	☐ No FSH ≥ 15 mIU/mL &/or E2 ≥ 80 pg/ml for females < age 41
12. FSH on day 3 is < 12 mIU/mL and Estradiol (E2) ,80 pg/mL for females ≥ age 42 (CCCT within 1 year & day 3 FSH within 6 month required on women ≥ age 40) * Must provide copy of FSH/E2 lab results for all requests	☐ Yes Day 3 FSH _____ E2 _____ Date _____	☐ No FSH ≥ 12 mIU/mL &/or E2 ≥ 80 pg/mL for females ≥ age 42 FSH ≥ 12 mIU/ml and/or E2 ≥ 80 pg/ml for females ≥ 42 Day 3 FSH _____E2 _____ Date _____ *Must provide copy of FSH/E2 lab results for all requests
B. Information for all Gonadotropin/IUI coverage requests (check all that apply in addition to part A above)		
1. Has previously completed any ART\cycles	☐ No	☐ Yes
2. Currently age < 44 and meets guidelines	☐ Yes: May authorize up to 2 medicated IUI cycles	☐ No: Age ≥44 Has a history of ≥ 2 medicated IUI cycles
C. Information for all ART coverage requests (check all that apply in addition to part A above)		
1. Medicated IUI History	☐ 1-2 cycles of FSH/IUI	
2. Total # of previous ART cycles	_____ ART cycles	☐ ≥ 5 ART cycles (must send summary of previous ART cycles)
3. Uterine Cavity evaluation: HSG, SHG or HSC (Repeated every two years)	☐ Yes: Date _____	☐ No: Please provide medical rationale for exception
4. Semen analysis > 10 mil Total Motile Sperm (TMS) (Completed within 1 yr)	☐ Yes: Date _____	☐ No: (TMS) Results _____ Date_____ (If < 10 mil TMS, and male factor, provide 2 SA results and urology consult notes)
5. TSH level < Age 35 Completed within 2 yrs ≥ Age 35 Completed within 1 yr	☐ Normal: Date_____	☐ Abnormal Results _____ Date_____
6. Requesting freeze-all cycle	Reason for freeze-all (supporting documentation required): ☐ Member requires medical treatment that can cause sterility ☐ Member meets guidelines for IVF and is also approved by THP for PGD ☐ Member meets guidelines for IVF and is privately paying for PGS for suspected aneuploidy (with multiple prior spontaneous abortions of unclear etiology)	☐ Other _____ _____