



INFERTILITY TREATMENT PRIOR APPROVAL REQUEST FORM

One Monarch Place, Suite 1500 Springfield, MA 01144-1500
413-787-4000 or 800-842-4464 • Health Services Fax: 413-233-2700

PLEASE PRINT OR TYPE. SEND COPY OF COMPLETED FORM VIA FACSIMILE TO: HEALTH SERVICES MANAGEMENT (FAX: 413-233-2700)

FROM: (Infertility Specialist/Provider) MEMBER ID #: DOB:
DATE: (Provider Number)
MEMBER NAME: PARTNER'S NAME:
ADDRESS:

COMPLETE SECTIONS A & B BELOW: FULLY-FUNDED SELF-FUNDED (HNE USE ONLY)

DIAGNOSIS: Male Factor Tubal Hormonal Endometriosis/Adhesions Unexplained Other:

ART TREATMENT REQUESTED: IUI Gonadotropin/IUI IVF FET ICSI AH(Assisted Hatching) Donor Egg Other:

A. IUI: 1. Female age: Gravid: Para: Ectopics:
Yes/No
2. Inability to conceive during a period of one year with unprotected intercourse or 12 supervised exposures to donor sperm.
B. GONADOTROPIN/IUI:
3. Completed at least 3 cycles of Clomiphene Citrate and IUI prior to approval of FSH/IUI cycles.
4. History of voluntary sterilization or reversal of voluntary sterilization.
a. Male b. Female
5. History of smoking within last 3 months.
a. Male b. Female

Yes/No
6. Proposed for the purpose for surrogacy, gestational carrier, or donation or sale of gametes or embryos.
7. Rubella Immune
8. Normal TSH w/in 1 year
9. Normal HSG or SHG (w/in 1 year)
10. Normal Semen Analysis (w/in 1 year)
Day 3 FSH levels must be <=13 and Day 3 Estradiol levels must be <80.
11. FSH/Estradiol levels (w/in 1 year < 40; >= 40 within 6 months)
a. Day 3 Date: FSH: E2:
b. Day 3 of CCT if >=40 y/o Date: FSH: E2: (Annually)
c. Day 10 of CCT if >=40 y/o Date: FSH: E2: (Annually)

C. COMPLETE FOR IVF REQUESTS:

Yes/No 1. Completed FSH/IUI cycles.
a. If <40, 3-4 cycles
b. If >=40, 1-2 cycles
c. None Severe Male Factor Severe Tubal Factor
Yes/No 2. Prior ART Cycles.
If yes, how many: Fresh cycles Frozen embryos
3. Number of ART cycles since birth of last child:
4. Semen banking / storage required. (HNE covered Partner Only and only during an active cycle)

PLEASE SUBMIT THE FOLLOWING:

- 1. For all ART - HSG or SHG report w/in 1 year (an HSG is required if the diagnosis is tubal factor) and the Prior ART summary sheets.
2. For ICSI - copies of 2 abnormal semen analyses (at least 2 weeks apart) or prior cycle summary documenting poor or failed fertilization.
3. Donor Egg Therapy - FSH and Estradiol levels
4. For conversion from IUI to IVF cycles - Member must be <=40 years old and E2 >=1000 pg/ml with 5 mature follicles and submit stimulation sheet.

HNE INFERTILITY TREATMENT AUTHORIZATION REQUEST DECISION (HNE USE ONLY)

Additional Information Needed/Submitted Requested: Received:
Approved Authorization #: Cycles/Attempts: Approval Start/End Dates:
Referral is for:
Please forward a report of cycle outcomes to HNE. Decision: Signed:
Date Time
Denied (see separate letter) PR Signature:
Initial Notice: Confirmation Notice:
Date Time Person Notified at Provider (Rendering Service) Office Initials Date Initials

FOR ALL INFERTILITY REQUESTS, PLEASE COMPLETE THE SECTION BELOW:

To the best of my knowledge the information on this form is true and complete. We understand that all services must be approved in advance by HNE and that HNE will send written notice of the decision. The written notice will be sent to our office as well as to the patient before the requested services are provided.

Sincerely, Physician Signature: