Minuteman Health℠

INFERTILITY TREATMENT PRIOR APPROVAL REQUEST FORM

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

Form: _____ _____
(Infertility Specialist/Provider) (Provider Name)

Date: _____

Member Name: _____

Address: _____

_____

Member ID #: _____ DOB: _____

Partner's Name: _____

COMPLETE SECTIONS A & B BELOW:

☐ Fully-Funded ☐ Self-Funded ☐ GIC (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: ____ Gravida: ____ Para: ____ Ectopics: ____

Yes	No	
☐	☐	2a.**For under age 35**: Inability to conceive during a period of one year with unprotected intercourse or 12 physician office based IUI's with donor sperm.
☐	☐	2b. **For ages over 35:** Inability to conceive during a period of 6 months with unprotected intercourse or 6 physician office based IUI's with donor sperm.
		3. History of voluntary sterilization or reversal of voluntary sterilization.
☐	☐	a. Male
☐	☐	b. Female
		4. History of smoking, drug abuse within last 6 months. If yes,
☐	☐	a. Male - negative cotinine level or drug screen and date
☐	☐	b. Female - negative cotinine level or drug screen and date
		5. BMI: _____ Height: _____ Weight: _____
		5a. **BMI ≥ 40** - must be submitted prior to approval of IVF and/or IUI cycle
☐	☐	Six months of active participation in weight loss program
☐	☐	Maternal Fetal Medicine Consult with documentation of obesity associated maternal and fetal risks
☐	☐	Anesthesiology Consult prior to IVF cycle

Yes	No	
☐	☐	5b. **BMI ≥ 35** - must be submitted prior to approval of IVF and/or IUI cycle
☐	☐	Nutrition Consult and 6 months of weight loss attempts
☐	☐	Anesthesiology Consult prior to IVF cycle
☐	☐	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 (within 2 years)
☐	☐	10. Normal Semen Analysis (within 1 year) If no, see #2 below

Day 3 Estradiol levels must be <80 and Day 3 and 10 FSH levels must be < 15 if under 42 and <or equal to 12 if > or equal to 42 years of age. Annual Clomid Challenge Test required if > or equal to 40 years old.

11. FSH/Estradiol levels (within 1 year < 40; if ≥ 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)

B. COMPLETE FOR IVF REQUESTS:

Yes	No	
		1. Completed ovulation induction cycles
☐	☐	a. If ≤ 40, 3 cycles of ovulation induction (clomid or FSH) with IUI
☐	☐	b. If ≥ 40, 2 cycles of ovulation induction (clomid or FSH) with IUI
		c. If none: ☐ Severe Male Factor ☐ Severe Tubal Factor

Yes	No	
☐	☐	2. Prior ART Cycles If yes, how many and when: _____ Fresh cycles _____ Current # of Frozen embryos **_____ (see #6 below)**
		3. Number of ART cycles since birth of last child: ____
☐	☐	4. Semen banking / storage required. (MHI covered Partner Only and only during an active cycle)

PLEASE NOTE:

1. For all ART - Please submit HSG or SHG report within 1 year (an HSG is required if the diagnosis is tubal factor) and all prior ART summary sheets.
2. For ICSI - Please submit copies of 2 abnormal semen analyses (at least 2 weeks apart) or prior cycle summary documenting poor or failed fertilization.
3. Donor Egg Therapy - Please submit the Abnormal FSH with Estradiol levels drawn before 40 years of age, they do not need to be repeated for donor egg before age 40. Please submit documentation of completed IVF cycles and a normal CCCT for a donor egg request after 40 years of age.
4. For conversion from IU I to IVF cycles - Member must be $\leq$ 40 years old and E2 $\geq$ 800 pg/ml with 3 mature follicles and submit stimulation sheet.
5. An FET cycle may be approved with only a normal uterine cavity evaluation and a definition of infertility; repeat day 3 FSH and E2 are not required.
6. A repeat fresh IVF cycle may not be approved for a woman < or equal to 35 if there are at least a total of 2 frozen embryos from prior IVF cycles of 4 frozen embryos for a woman > 35 years of age.

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 Minuteman Health, Inc. (MHI) and that MHI 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:

_____