



infertility services preauthorization request form

Requested service(s): _____

Servicing infertility specialist and facility: _____

| | patient | partner |
|--|---------|---------|
| Name: | | |
| DOB: | | |
| FCHP Member ID#: | | |
| Diagnosis: | | |
| How long trying to conceive? | | |
| Indicate if history of voluntary sterilization or reversal and date: | | |

| test or procedure | date completed | results |
|--|----------------|---------|
| HSG/Hysteroscopy, Laparoscopy | | |
| Under 40: Most recent day 3 FSH and E2 | | |
| 40 and Older: CCCT (within the last 6 months) including day 3 and 10 FSH; day 3 E2 | | |
| List all previous treatments (IUI, IVF or donor egg) | | |
| List outcome (e.g., live birth, ectopic, miscarriage, D&E) and dates of all previous pregnancies | | |
| Semen analysis | | |

Please attach initial consultation for first requested ART cycle as well as ART summary sheets and clinical notes for any previous ART cycles

Completed by: Name: _____ Referring physician: _____
 (Please print) Phone: _____ Date: _____

Fax completed form to the FCHP Infertility Coordinator at 1-508-368-9700 along with the Prescription Prior Authorization Form. For questions, please call 1-508-368-9840.



supplemental fchp prescription prior authorization form fertility medications

Patient name: _____ DOB: _____

MD name: _____ Phone: _____ Fax: _____

MD signature: _____ Date: _____

| medication & strength | daily dose | dose duration | vials/pens per cycle |
|---|------------|---------------|----------------------|
| <input type="checkbox"/> Gonal-F 450 unit vial* | | | |
| <input type="checkbox"/> Gonal-F 600 unit vial* | | | |
| <input type="checkbox"/> Gonal-F 1050 unit vial* | | | |
| <input type="checkbox"/> Gonal-F RFF 75 unit vial* | | | |
| <input type="checkbox"/> Gonal-F RFF 300 unit pen* | | | |
| <input type="checkbox"/> Gonal-F RFF 450 unit pen* | | | |
| <input type="checkbox"/> Gonal-F RFF 900 unit pen* | | | |
| <input type="checkbox"/> Follistim AQ 75 unit vial | | | |
| <input type="checkbox"/> Follistim AQ 150 unit vial | | | |
| <input type="checkbox"/> Follistim AQ 300 unit pen | | | |
| <input type="checkbox"/> Follistim AQ 600 unit pen | | | |
| <input type="checkbox"/> Follistim AQ 900 unit pen | | | |
| <input type="checkbox"/> Bravelle 75 unit vial | | | |
| <input type="checkbox"/> Fertinex 75 unit vial | | | |
| <input type="checkbox"/> Fertinex 150 unit vial | | | |
| <input type="checkbox"/> Repronex 75 unit vial* | | | |
| <input type="checkbox"/> Menopur 75 unit vial | | | |
| <input type="checkbox"/> Luveris 75 unit vial | | | |
| <input type="checkbox"/> HCG 10,000 unit vial | | | |
| <input type="checkbox"/> Ovidrel 250 mcg syr | | | |
| <input type="checkbox"/> Cetrotide 250 mcg vial | | | |
| <input type="checkbox"/> Cetrotide 3 mg vial | | | |
| <input type="checkbox"/> Ganirelix 250 mcg syr | | | |
| <input type="checkbox"/> Crinone 8% gel | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

Note: No PA required for Lupron, clomiphene, progesterone in oil, or progesterone suppositories.

Services are subject to coverage, benefit, network and contract policies and exclusions.

*Indicates preferred medication.

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For pharmacy use only

Approved for: _____ Expires: _____

Denied. Reason: _____

Other notes: _____

Reviewed by: _____ Date: _____

FCHP form #: _____ FCHP date received: _____