



Infertility Services Prior Authorization Request Form

Servicing infertility specialist and facility:

Requested service(s) and codes:

Service: _____ Code: _____ Service: _____ Code: _____

Service: _____ Code: _____ Service: _____ Code: _____

Service Embryo storage for one year Code: 89342 Yes No

	Patient	Partner
Name:		
DOB:		
FCHP Member ID#:		
Diagnosis:		
How long trying to conceive?		
Indicate if history of voluntary sterilization:		

Test or procedure	Date completed	Results
HSG/hysteroscopy, laparoscopy		
Day 3 FSH and E2 within the last 12 months		
List all previous treatments (IUI, IVF or donor egg), including dates		
List outcome (e.g., live birth, ectopic, miscarriage, D&E) and dates of all previous pregnancies		
Semen analysis		
Current substance abuse (Smoking, ETOH, etc) for the member and partner		
BMI		

Please attach all infertility consultation notes as well as ART summary sheets and clinical notes for any previous ART cycles.

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

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

Supplemental FCHP Prescription Prior Authorization Form for Fertility Medications

Patient name: _____

DOB: _____ FCHP ID#: _____

M.D. name: _____ M.D. NPI: _____

Phone: _____ Fax: _____

M.D. signature: _____ Date: _____

Medication and strength	Daily dose	Dose duration	Vials/pens per cycle
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*Note: For Gonal-F initial requests over the limit of 1800 IU for a 10 day cycle (IUI) or 2700 IU for a 10 day cycle (IVF); and for Gonal-F requests for mid-cycle increases; and for all Follistim AQ requests: **In addition** to the below information, please submit the appropriate Gonal-F or Follistim AQ PA form and worksheet. These can be found at: fchp.org/providers/pharmacy/pharmacy-prior-authorization.aspx.*

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

* Indicates preferred medication.

Fax completed form to the FCHP Infertility Coordinator at 1-508-368-9700 along with the Infertility Services Preauthorization Form. For medication questions, please call 1-508-368-9825, option 5.

FCHP form #: _____ FCHP date received: _____