HNE
HEALTH NEW ENGLAND
One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413-787-4000 · 800-842-4464

INFERTILITY TREATMENT PRIOR APPROVAL REQUEST FROM

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

From: _____ _____
(Infertility Specialist/Provider) (Provider Number)

Date: _____

Member Name: _____

Address: _____

_____

Member ID #: _____ DOB: _____

Partner's Name: _____

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: _____ 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 within last 6 months.
❑	❑	a. Male - negative serum or urine cotinine level
❑	❑	b. Female - negative serum or urine cotinine level
		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
❑	❑	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
❑	❑	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 (w/in 2 years)
❑	❑	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 ovulation induction cycles
❑	❑	a. If ≤ 40, 3 cycles of ovulation induction with IUI
❑	❑	b. If ≥ 40, 3 cycles of medicated IUI with at least one cycle with FSH
		c. None ❑ Severe Male Factor ❑ Severe Tubal Factor

Yes	No	
		Current # of
❑	❑	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 before 40 years of age, or documentation of completed IVF cycles and a normal CCCT after 40 years of age.
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.

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: _____