



Infertility Services PRIOR AUTHORIZATION REQUEST FORM

NOTE: PLEASE ATTACH SUPPORTING CLINICAL INFORMATION WITH ALL REQUESTS
INCOMPLETE INFORMATION MAY DELAY PROCESSING OF REQUEST
FAX TO: **617-951-3464** (initial requests); **617-951-3461**(additional clinical information)

Member Name: _____ DOB: _____ BMCHP ID #: _____
 Requesting Provider Name: _____ NPI #: _____
 ART Facility Provider Name: _____ NPI #: _____
 Submitted by: _____ Direct Phone #: _____ Fax #: _____
Who sent in the form?

Prior to submitting this request, Plan network providers are required to access the Clinical Coverage Guidelines for Infertility Services (Policy #: OCA: 3.725) at <http://bmchp.org> (to be updated when policy posted to the web) to verify that the member meets the Plan’s definition of infertile, the eligibility and evaluation requirements, and the coverage criteria for the specific service being requested.

REQUIRED CLINICAL INFORMATION:

Please submit the information below as required for the requested service (see Clinical Coverage Guideline).

Length of time trying to conceive (months/years)	
Diagnosis (description and code)	
Requested Service (description and code)	
Pregnancy dates & outcomes (if additional space needed submit with clinical information)	
BMI (kg/m2)	

Please check the boxes below that correspond to the information submitted with this request.

For Evaluation of the Female:	
	Rubella Immunity status – Note: all non-immune members must be vaccinated 1 month before seeking approval for ART
	Smoking status – Note: urine or serum cotinine levels required for members who quit smoking within the past 6 months
	Thyroid stimulating hormone (TSH) level
	Follicle stimulating hormone (FSH) and estradiol (E2) levels
	Clomiphene citrate challenge test (CCCT) result
	Normal uterine cavity evaluation within 1 year prior to the initial ART cycle
	History of FSH/IUI cycles and ART cycles
	BMI-related evaluations: <ul style="list-style-type: none"> • Anesthesiology consult within 6 months prior to the initial approval of coverage for an IVF cycle • Nutrition consult within the previous 6 months • Maternal fetal medicine/high risk obstetrics consult within the previous 6 months
Evaluation of the Male:	
	Semen analysis – Note: tests completed within 1 year of this request
	Smoking status – Note: urine or serum cotinine levels required for members who quit smoking within the past 6 months
	Evaluation by an urologist or reproductive endocrinologist
	Follicle stimulating hormone (FSH) and testosterone levels
	Karyotyping and Y chromosome microdeletion (YCMD) testing results
	Cystic fibrosis screening results