



Infertility Injectable Medication Precertification Request (CPB #0327)

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Please return both pages for precertification of medications.

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please note that authorizations are valid for one cycle only and a request form must be submitted for each cycle.

Please indicate: Start of treatment Continuation of therapy, date of last treatment cycle _____ **Today's date:** _____

Date needed: _____

Ship to: Doctor's office Patient Other: _____ **Phone:** _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	Patient Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:			(Circle one): M.D. D.O. N.P. P.A.	
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:			Phone:	
Specialty (Circle one): Reproductive Endocrinologist Medical Endocrinologist Ob/Gyn Other: _____					

D. DIAGNOSIS INFORMATION

Please indicate type of cycle: Non-donor IVF cycle Donor IVF cycle Frozen Embryo transfer cycle Ovulation Induction with IUI
 Other (please specify) _____

E. CLINICAL INFORMATION

Yes No Has the patient enrolled with Aetna's Infertility Program (1-800-575-5999) for approval of medical (non-drug) services for this cycle?
Please indicate whether the patient meets either of the following criteria:
 Yes No Patient is 35 years of age or younger and has been unable to conceive or produce conception after one year of frequent unprotected heterosexual intercourse OR without male partner, at least 12 cycles of egg and sperm contact (e.g., donor insemination).
 Yes No Patient is over 35 years of age and has been unable to conceive or produce conception after six months of frequent unprotected heterosexual intercourse OR without male partner, at least 6 cycles of egg and sperm contact (e.g., donor insemination).
****This medical definition may vary due to state mandates and plan customization.****

Yes No Has the patient or patient's partner had a previous sterilization procedure, with or without surgical reversal, or has the female undergone a hysterectomy?

Yes No Has the patient previously completed any of the following cycles? If Yes, please indicate below the infertility treatments the patient has previously received:
 Yes No Injectable Ovulation Stimulation
 Yes No Non-Donor IVF/GIFT/ZIFT
 Yes No Donor IVF
****If this is not the first cycle, please provide most current cycle sheet.****

Laboratory criteria:
Please provide the following Lab Values:
Day 3 FSH (serum FSH measured on cycle day 3): _____ Day 3 Estradiol (E2) _____ Date: _____



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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F. PRESCRIPTION – To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

Follistim AQ (non-preferred)
 300 IU Cartridge # _____
 600 IU Cartridge # _____
 900 IU Cartridge # _____
 Follistim Pen # **1 pen**
 75 IU Vial # _____
 150 IU Vial # _____
 Sig: _____

Gonal-F/Gonal-F RFF (preferred)
 300 IU Pen # _____
 450 IU Pen # _____
 900 IU Pen # _____
 75 IU Vial # _____
 450 IU Vial # _____
 1050 IU Vial # _____
 Sig: _____

Bravelle (preferred) 75 IU # of Vials _____
 Sig: _____

Menopur 75 IU # of Vials _____
 Sig: _____

Repronex 75 IU # of Vials _____
 Sig: _____

Cetrotide
 0.25 mg Kit # _____
 3 mg Kit # _____
 Sig: _____

Ganirelix 250 mcg # of PFS _____
 Sig: _____

Luveris 75 IU # of Vials _____
 Sig: _____

Leuprolide 2 Week Kit # of Kits _____
 Sig: _____

Ovidrel 250 mcg # of PFS _____
 Sig: _____

Generic HCG, Novarel or Pregnyl 10,000 IU
 # of Vials _____
 Sig: _____

Crinone 8% Gel (15/box) # of Boxes _____
 Sig: _____

Prometrium
 100 mg Capsule # _____
 200 mg Capsule # _____
 Sig: _____

Methylprednisolone
 4 mg Tablet # _____
 8 mg Tablet # _____
 16 mg Tablet # _____
 Sig: _____

Endometrin 100 mg # of Supp _____
 Sig: _____

* **Please note: When ordering more than a quantity of 8 Vivelle Dots, call 1-800-414-2386 for a max dose override.**

***Vivelle Dot (8/box)**
 0.05 mg # of Boxes _____
 0.1 mg # of Boxes _____
 Sig: _____

Estradiol
 0.5 mg Tablet # _____
 1 mg Tablet # _____
 2 mg Tablet # _____
 Sig: _____

Progesterone in Sesame Oil 50mg/ml 10ml Vial
 # of Vials _____
 Sig: _____

Other: _____
 # _____
 Sig: _____

COMPOUNDED MEDICATIONS – These will no longer be filled through Aetna Specialty Pharmacy. Prescriptions for compounded medications will be forwarded to CVS/Caremark at 1-877-408-9742.

HCG low dose _____ Units per _____ ml
 # of milliliters _____ # of Refills _____
 Sig: _____

Lupron Microdose
 _____ mcg/0.1ml # of ml _____ # of Refills _____
 _____ mcg/0.2ml # of ml _____ # of Refills _____
 Sig: _____

Progesterone Vaginal Suppositories
 100 mg Capsule # _____ # of Refills _____
 200 mg Capsule # _____ # of Refills _____
 Sig: _____

Progesterone Vaginal Capsules
 100 mg Capsule # _____ # of Refills _____
 200 mg Capsule # _____ # of Refills _____
 Sig: _____

Progesterone Oral Capsules
 100 mg Capsule # _____ # of Refills _____
 200 mg Capsule # _____ # of Refills _____
 Sig: _____

Progesterone in _____ Oil
 50 mg/ml # of vials _____ # of Refills _____
 Sig: _____

SUPPLIES

<input type="checkbox"/> 3 ml syringe # _____	<input type="checkbox"/> 22g 1-1/2" needle # _____
<input type="checkbox"/> 27g 1/2" needle # _____	<input type="checkbox"/> 25g 1-1/2" needle # _____
<input type="checkbox"/> 30g 1/2" needle # _____	<input type="checkbox"/> 18g 1" needle # _____
<input type="checkbox"/> Insulin Syringes 1/2 cc # _____	<input type="checkbox"/> Pen Needle 29G 1/2" # _____
<input type="checkbox"/> Other Syringes/Needles Size _____ # _____	

* If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
 * If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: _____ Date: ____/____/____

(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "Brand Medically Necessary" in this space. _____