

**Infertility Services
Information Request Form**

**Applies to:
Aetna International**



Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

Infertility Services Information Request Form

About this form

This form will help you supply the right information with your request. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

How to fill out this form

As the patient's attending physician, you must complete all sections of the form. Please complete this form at least 15 days prior to the planned treatment start date. You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

Infertility Medications

Once you've completed this form for infertility treatment, if the member has pharmacy benefits for injectable medications through Aetna, complete the Female Infertility Injectable Medication Request Form. You can find the specialty pharmacy form at [aetna.com/health-care-professionals/health-care-professional-forms.html](https://www.aetna.com/health-care-professionals/health-care-professional-forms.html)

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Department:

- We prefer you submit this form requests electronically to S021027@aetna.com

What happens next?

Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic response.

How we make coverage determinations

The Clinical Policy Bulletins referenced will be used as a resource in decision making. We encourage you to review **Clinical Policy Bulletin #327: Infertility** and **Clinical Policy Bulletin #358: Invasive Prenatal Diagnosis of Genetic Diseases**, before you complete this form. You can find the Clinical Policy Bulletins and Lists by visiting the website on the back of the member's ID card. Prior treatment approval does not guarantee approval for ongoing or future treatment.

Questions?

If you have any questions about how to fill out the form or our process, call us at:

- [800-575-5999](tel:800-575-5999) (TTY: [711](tel:711)) and follow the prompts to connect with Aetna's Infertility Department.

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Section 1: Provide the following general information

Member name:	Reference number (required):
Member ID:	Member date of birth: / /
Member preferred contact number () -	
Member assigned gender at birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Member identified gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary
Requesting Provider and/or group name:	Provider or group Address:
Provider or group TIN:	Provider or group fax number:
Contact name of office personnel to call with questions:	Telephone number (with extension): - - ext.

Section 2: Treatment Plan

Requested service:	
<input type="checkbox"/> Intrauterine Insemination (IUI) Medication used: _____ <input type="checkbox"/> Pre-Implantation Genetic Screening (PGT-A/PGS) <input type="checkbox"/> Pre-Implantation Genetic Diagnosis (PGT-M, PGT-SR) Please submit genetic testing results with this request for both male and female (when applicable) <input type="checkbox"/> Cryopreservation <input type="checkbox"/> Thawing <input type="checkbox"/> Storage <input type="checkbox"/> Social Fertility Preservation <input type="checkbox"/> Iatrogenic Fertility Preservation	<input type="checkbox"/> Complete In Vitro Fertilization (IVF) <input type="checkbox"/> In Vitro Fertilization (IVF) Freeze All <input type="checkbox"/> Assisted Hatching (AH) <input type="checkbox"/> Intra-cytoplasmic Sperm Injection (ICSI) <input type="checkbox"/> Frozen Embryo Transfer (FET) <input type="checkbox"/> Egg/Thaw/Fert/No Transfer <input type="checkbox"/> Other (please specify) _____
Planned start date of current treatment cycle requested: / /	Donor sperm: <input type="checkbox"/> Yes <input type="checkbox"/> No Donor eggs: <input type="checkbox"/> Yes <input type="checkbox"/> No Donor embryo: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 3: Member's Clinical History

Cycle Day 3 Bloodwork	
FSH Level:	E2 level:
Date of last menstrual period (LMP) with Day 3 bloodwork: / /	
Date collected (must be drawn within the past 6 months): / /	
Has member taken any estrogen (including birth control) within the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list medication(s):	
Does the member currently have a partner? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the partner: <input type="checkbox"/> Male <input type="checkbox"/> Female Partner's Full Name: _____
Is the member currently trying to conceive with their current partner? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long with this partner? _____

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Member name:

Reference number:	Member ID:
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Section 3: Member's Clinical History, continued

Is there a history of sterilization for the member? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has a reversal been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is there a history of sterilization for the partner? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has a reversal been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the member have regular cycles: Yes No **If not, how many cycles per year?** _____

Previous pregnancy history/outcome:

Never been pregnant:

Month/year of pregnancy (Please include if infertility therapy was used/was there a fetal heartbeat confirmed (if loss)/gestational age at time of loss or birth): _____

Section 4: Provide ONLY the following documentation for your request

- **First treatment request with Aetna and/or last treatment request was over one year ago:**
 - Time trying to conceive OR medical history which led to diagnosis of infertility
 - History of sterilizations
 - Cycle Day 3 bloodwork
 - If prior request was over a year ago:**
 - Is the member still with the same partner (if applicable)
 - Have there been any history of sterilizations since last treatment

- **OI, IUI, and timed intercourse cycles:**
 - Medication to be used (if any)
 - Time trying to conceive OR Medical history which led to diagnosis of infertility
 - All previous IUI cycles (if applicable)
 - History of sterilizations
 - Cycle Day 3 bloodwork

- **Initial ART Cycle:**
 - Indication for advanced reproductive technology (ART) treatment request
 - Time trying to conceive OR Medical history which led to diagnosis of infertility
 - All previous IUI cycles (if applicable)
 - History of sterilizations
 - Cycle Day 3 bloodwork

- **Additional ART cycle requests:**
 - Cycle Day 3 bloodwork
 - Complete #5 in Section 5 for previous ART cycles including embryology report

- **PGT-M or PGT-SR:**
 - Genetic testing reports for member and partner (when applicable)
 - Karyotype report if requesting PGT-SR for member and partner (when applicable)

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Member name:

Reference number: _____ **Member ID:** _____

Section 5: Advanced Reproductive Technology (ART) Requests

1. Completion of previous ovulation induction (OI) cycles: Please Note: Only include the below treatments that were done by the member you are currently requesting treatment for or indicate clearly if the partner was the one completing the below: Only include the medication information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the medication.:

Cycle #	Medication taken for OI Cycle	Month/Year Completed/Outcome	IUI or Timed Intercourse
1			
2			
3			

2. Endometriosis or pelvic surgeries: Submit the operative report. Include stage of endometriosis (if applicable).

3. Tubal factor: A hysterosalpingogram (HSG) is required. Submit the HSG with dye report. Do not include Sono HSG or Femvue. History of ectopic pregnancy during infertility treatment: Yes No

4. Male factor: Submit two (2) abnormal semen analyses at least two (2) weeks apart for the request of ICSI. May include sperm prep reports.

5. Previous ART cycles: Fill in below for each ART cycle.

IVF: Only include the information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the treatment

Retrieval date: / /	Retrieval date: / /	Retrieval date: / /
# of oocytes retrieved:	# of oocytes retrieved:	# of oocytes retrieved:
# of oocytes with conventional insemination:	# of oocytes with conventional insemination:	# of oocytes with conventional insemination:
# of oocytes with ICSI:	# of oocytes with ICSI:	# of oocytes with ICSI:
# of oocytes fertilized:	# of oocytes fertilized:	# of oocytes fertilized:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos cryopreserved:	# of embryos cryopreserved:	# of embryos cryopreserved:
# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:
Results of PGD/PGS:	Results of PGD/PGS:	Results of PGD/PGS:

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Member name:		
Reference number:		Member ID:
Continued: Previous ART cycles: Fill in below for each ART cycle.		
FET: Only include the information below if applicable for the member you're currently requesting treatment; or note if the partner was receiving the treatment		
Transfer date: / /	Transfer date: / /	Transfer date: / /
# of embryos thawed:	# of embryos thawed:	# of embryos thawed:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos still frozen:	# of embryos still frozen:	# of embryos still frozen:
Section 6: Read this important information		
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.		
Section 7: Sign the form		
Signature of person completing form:		
Today's date: / /		