

Physician's name and address:

Current date: _____

Patient's name: _____

Highmark BCBS DE ID #: _____

**Please fax completed form and any supporting clinical documentation and/or information to the Medical Management and Policy Department for Prior Authorization of In Vitro Fertilization(IVF):
 Fax: 800.670.4862 (Delaware) or 888.236.6321**

For **In Vitro Fertilization**, please complete the following questionnaire and forward to Claims Review for an IVF coverage determination.

BRIEF PATIENT HISTORY:
INFERTILITY WORK-UP AND TREATMENT/MEDICATIONS/SURGERY/TO DATE - LIST TESTS AND RESULTS:
PLEASE SPECIFY THE CAUSE OF INFERTILITY:
PROPOSED TREATMENT:

Has the patient had a tubal ligation? Yes No

Has the spouse had a vasectomy? Yes No

Are you a Blue Cross Blue Shield participating provider? Yes No

Blue Cross Blue Shield Provider ID # : _____

Signature: _____

Person's Name completing this form: _____

Office phone number: () _____

State of Delaware Guidelines for First Line IVF Therapeutic Treatment

Advanced Maternal Age

- Female partner \geq age 35 after attempting conception for \geq 6 months

Infertility with Diminished Ovarian Reserve (Any Age)

- AMH $<$ 1.0
- Early follicular FSH \geq 10.0
- Persistent bilateral AFC \leq 5.0
 - Total ie both ovaries consistent over 2 to 3 determinations

Male factor

- Ejaculated sperm unsuitable for IUI (poor count, motility, or morphology)
 - $<$ 5 million total motile sperm
 - $<$ 5% normal morphology by strict Kruger criteria
- Partner sperm only obtainable from urine (retrograde ejaculation)
- Partner sperm only obtainable via electroejaculation procedure
- Partner sperm only obtainable via epididymal aspiration and/or testicular biopsy

Tubal disease

- Idiopathic or iatrogenic irreparable bilateral tubal occlusion
- Prior bilateral salpingectomy
- Bilateral hydrosalpinx
- Severely abnormal tubes based on laparoscopic assessment

Infertility with history of Pelvic adhesions

- Severe adhesive disease diagnosed by laparoscopy

Infertility with history of Prior laparotomy

- Laparoscopic evaluation is contraindicated
- Severe pelvic adhesions diagnosed by laparoscopy

PCOS

- In setting where ovulation induction does not produce follicular growth with oral agents (e.g. clomiphene, letrozole)
- In setting where $>$ 2 dominant follicles routinely result from oral agents
- In setting where $>$ 3 ovulation induction cycles fail to result in conception

Recurrent pregnancy loss

- ≥ 3 clinical pregnancy losses (pregnancy confirmed by ultrasound) if maternal age < 35 and negative evaluation for underlying cause of losses
- ≥ 2 clinical pregnancy losses (pregnancy confirmed by ultrasound) if maternal age ≥ 35 and negative evaluation for underlying cause of losses

Balanced chromosome translocation

- In either female or male partner where PGT-SR would be carried out

High risk for genetic disease in offspring

- Dominant disorder in either partner where PGT-M would be carried out
- Same recessive disorder in both partners where PGT-M would be carried out

Fertility preservation

- Embryo creation or oocyte cryopreservation in setting of cancer or other diseases where treatments are toxic to ovaries and oocytes

Requires gestational carrier

- Prior hysterectomy
- Severe uterine anomaly
- Pregnancy medically contraindicated

Unexplained infertility after failed OI/UI

- No successful conception after 3 properly managed ovulation induction cycles, with or without intrauterine inseminations by either an OBGYN or an REI.