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MASSACHUSETTS

PRIOR AUTHORIZATION REQUEST FORM

Assisted reproductive technology services or preimplantation genetic testing

Non-participating providers (commercial members):
Fax completed form to **1-800-836-1112**

Blue Cross participating providers:
- Use Authorization Manager (see below)
- For Federal Employee Program members living outside of Massachusetts: Fax completed form to **1-888-282-1315**

WHEN TO USE THIS FORM

Complete and submit this form when requesting authorization for assisted reproductive technology services or preimplantation genetic testing. For commercial members, refer to medical policies 086 and 088 for coverage criteria. For Federal Employee Program members, refer to member plan brochures at fepblue.org.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDERS MUST USE AUTHORIZATION MANAGER ETOOL

To request initial authorization for these services, Blue Cross Blue Shield of Massachusetts providers should use Authorization Manager, an electronic technology used to review authorization requirements, request authorizations, upload clinical documentation to an existing case, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:
- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, not the billing group.

Authorization Manager Resources
- Refer to our Authorization Manager page for tips, guides, and video demonstrations.

Provider information	
Provider name	Provider NPI
Provider address	Facility NPI
Facility name	Phone
Facility address	Is voicemail confidential at this number? ☐ Yes ☐ No
Provider contact name	Fax
	Is this fax number secured* to receive PHI? ☐ Yes ☐ No

*Our policy requires that we handle transmission of protected health information (PHI) in accordance with HIPAA protections.

Member information	
Member name	Member date of birth
Member health plan ID	
Partner's name	Partner's date of birth

Questions

Please attach clinical information to support medical necessity for the following

Member is undergoing chemotherapy or other treatment that is expected to render them infertile? ☐

Ovulatory disorder? ☐

Ovulatory disorder with exposure to sperm without conception for:
6 cycles <35 ☐ OR 3 cycles ≥35 ☐

Biological female with no biological male partner with exposure to sperm (IUI) for:
6 cycles <35 ☐ OR 3 cycles ≥35 ☐

Biological female with biological male partner inability to conceive, 12 months <35 ☐ OR 6 months ≥35 ☐

Has either partner been sterilized? OR Has either partner had a sterilization reversal?	☐ Yes ☐ No ☐ Yes ☐ No

Specific infertility diagnosis and procedure code(s):

Treatment to date: *Please attach*

Anticipated procedures that are medically necessary (check only the requested procedure)

☐ **IUI to IVF conversion** (medical emergency)	**Medical Fertility Preservation** ☐ cancer or ☐ other: _____ ☐ Egg ☐ Embryo ☐ Sperm	☐ **IVF/FET** (≤34yrs only)
IVF [select code(s)] Retrieval & Fresh Transfer ☐ S4015 (in state) ☐ 58970, 58974 (commercial plans - cryo & storage included for 24 months with approval)	**IVF Freeze All** [select code(s)] ☐ S4021 (in state) ☐ 58970 ☐ S4011 (out of state) (commercial plans - cryo & storage included for 24 months with approval)	**Frozen Embryo Transfer** (FET) [select code(s)] ☐ S4016 (in state) ☐ 58974 ☐ S4037 (out of state) **number of frozen eggs/embryos remaining**: _____
☐ **MESA** ☐ **TESE** ☐ **Donor Sperm**	**ICSI** ☐ S4022 (in state) ☐ 89280/1	☐ **Assisted Hatching**
Frozen Egg Fertilization with Freeze and/or Transfer ☐ S4037 (in state) ☐ 89356, 89280/1, 89258, 89342 ☐ 58974	**Embryo TBR** (thaw/biopsy/refreeze) ☐ S4018 (in state) ☐ 89352, 89290/1, 89258	**Preimplantation Genetic Testing** ☐ PGT-M (84999) ☐ PGT-SR (88299) **Specific genetic dx**: _____

Donor Egg:

Purchased Donor Egg (MEB/DEB) ☐ S4023	Anonymous or known donor, both sole recipient ☐ S4011	Anonymous donor ☐ S4011

Elective Procedures: (the following are covered ***only*** if specified in the member's subscriber certificate/rider):

☐ *Elective* Cryopreservation of egg
☐ *Elective* Cryopreservation of embryo
☐ *Elective* Cryopreservation of sperm
☐ PGT-A (81228)
☐ Elective Fertility Preservation
☐ Reciprocal IVF
☐ Elective Storage ☐ **Egg** (89346) ☐ **Embryo** (89342) ☐ **Sperm** (89343)

Diagnostic Tests required: *Please attach copies.
CCCT testing with appropriate dosing amounts: Day 3 FSH E2, clomid 100 mg P.O. day 5-9, and a day 10 FSH E2. CCCT (for > 39 and < 44 years old required yearly AND Day 3 FSH/Estradiol every 6 months in between Day 3 FSH and Estradiol (highest and most recent) OR alternate testing options as indicated in policy 086.

Must include one of the following: HSG/Hysteroscopy (for IUI) *OR* Uterine cavity evaluation (sonohysterogram/HSG, HyCosy, 3D ultrasound or Hysteroscopy), completed in the last 24 months Semen Analysis (for ICSI we only accept Kruger Morphology and there must be at least 2 samples per medical policy 086).