BlueCross BlueShield Federal Employee Program

ASSISTED REPRODUCTIVE TECHNOLOGIES (ART) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Cetrotide (cetrorelix)**	❑**Firmagon (degarelix)**	❑**Menopur (menotropins)**	❑**Synarel (nafarelin)**
❑**Clomiphene citrate**	❑**Follistim AQ (follitropin beta)**	❑**Progesterone in oil**	❑**Trelstar (triptorelin)**
❑**Clomiphene powder**	❑**Fyremadel (ganirelix)**	❑**Progesterone powder**	❑**Triptodur (triptorelin)**
❑**Crinone (progesterone)**	❑**Ganirelix (ganirelix)**	❑**Prometrium (progesterone)**	❑**Zoladex (goserelin)**
❑**Endometrin (progesterone)**	❑**Gonal-F (follitropin alfa)**	❑**Supprelin LA (histrelin)**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is this request for brand or generic? ❑Brand ❑Generic
2. Is the patient assigned female or male at birth? ***Please select answer below:***

❑**FEMALE:** What is the patient's diagnosis?

❑Gender dysphoria (GD), gender identity disorder (GID), sex transformation, or sex change
a. Is this medication being used for fertility preservation/egg retrieval? ❑Yes ❑No

❑Fertility preservation/egg retrieval

❑Menopause/hormone replacement treatment for menopause/menopausal symptoms

❑Miscarriage prevention in a currently pregnant patient

❑Infertility
a. Will the patient be undergoing an assisted reproductive technology (ART) procedure? ❑Yes* ❑No
***If YES**, which procedure will the patient be undergoing in combination with the requested medication(s)?

❑Artificial insemination (AI)
❑Embryo transfer and gamete intrafallopian transfer (GIFT)
❑In vitro fertilization (IVF)
❑Intracervical insemination (ICI)
❑Fertility preservation/egg retrieval
❑Intracytoplasmic sperm injection (ICSI)
❑Intrauterine insemination (IUI)
❑Intravaginal insemination (IVI)
❑Zygote intrafallopian transfer (ZIFT)
❑Frozen embryo transfer (FET)
❑**Other *(please specify)***: _____

❑Other ***(please specify)***: _____ ***(answer the following questions)***
a. Is the requested medication(s) being used to treat infertility? ❑Yes ❑No
b. Will the patient be undergoing an assisted reproductive technology (ART) procedure? ❑Yes* ❑No
***If YES**, please select answer below:

❑Artificial insemination (AI)
❑Embryo transfer and gamete intrafallopian transfer (GIFT)
❑In vitro fertilization (IVF)
❑Intracervical insemination (ICI)
❑Fertility preservation/egg retrieval
❑Intracytoplasmic sperm injection (ICSI)
❑Intrauterine insemination (IUI)
❑Intravaginal insemination (IVI)
❑Zygote intrafallopian transfer (ZIFT)
❑Frozen embryo transfer (FET)
❑**Other *(please specify)***: _____

❑**MALE:** What is the patient's diagnosis?

❑Gender dysphoria (GD), gender identity disorder (GID), sex transformation, or sex change

❑Erectile or sexual dysfunction

❑Prostate cancer

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES/QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. ART – FEP MD Fax Form Revised 10/18/2024

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Hypogonadism

a. Is the hypogonadism caused by primary testicular failure? ❑Yes ❑No***

***If NO**, is the patient being treated for hypogonadotropic hypogonadism? ❑Yes ❑No

b. Does the patient have low pretreatment testosterone levels? ❑Yes ❑No

c. Does the patient have low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels? ❑Yes ❑No

d. Is this medication being used for spermatogenesis? ❑Yes ❑No

❑Other ***(please specify)***: _____

3. Is the requested medication being used for weight loss, anti-aging effects, or performance (athletic) enhancement? ❑Yes ❑No

4. Is this medication being used to treat erectile dysfunction (impotence) or sexual dysfunction? ❑Yes ❑No

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