

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: <input type="checkbox"/> Male <input type="checkbox"/> 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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Cetrotide (cetrorelix) | <input type="checkbox"/> Firmagon (degarelix) | <input type="checkbox"/> Menopur (menotropins) | <input type="checkbox"/> Synarel (nafarelin) |
| <input type="checkbox"/> Clomiphene citrate | <input type="checkbox"/> Follistim AQ (follitropin beta) | <input type="checkbox"/> Progesterone in oil | <input type="checkbox"/> Trelstar (triptorelin) |
| <input type="checkbox"/> Clomiphene powder | <input type="checkbox"/> Fyremadel (ganirelix) | <input type="checkbox"/> Progesterone powder | <input type="checkbox"/> Triptodur (triptorelin) |
| <input type="checkbox"/> Crinone (progesterone) | <input type="checkbox"/> Ganirelix (ganirelix) | <input type="checkbox"/> Prometrium (progesterone) | <input type="checkbox"/> Zoladex (goserelin) |
| <input type="checkbox"/> Endometrin (progesterone) | <input type="checkbox"/> Gonal-F (follitropin alfa) | <input type="checkbox"/> Supprelin LA (histrelin) | |

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

- Is this request for brand or generic? ☐ Brand ☐ Generic
- 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

☐ Other (please specify): _____

☐ Intracytoplasmic sperm injection (ICSI)

☐ Intrauterine insemination (IUI)

☐ Intravaginal insemination (IVI)

☐ Zygote intrafallopian transfer (ZIFT)

☐ Frozen embryo transfer (FET)

☐ 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

☐ Other (please specify): _____

☐ Intracytoplasmic sperm injection (ICSI)

☐ Intrauterine insemination (IUI)

☐ Intravaginal insemination (IVI)

☐ Zygote intrafallopian transfer (ZIFT)

☐ Frozen embryo transfer (FET)

☐ **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

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**BlueCross
BlueShield**

Federal Employee Program.

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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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