Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCEND006.0425	**ENDOCRINE & METABOLIC DRUGS** **FERTILITY AND RELATED MEDICATIONS** (See Table 1 for medications)
Effective Date: 06/1/2025	**Review/Revised Date**: 04/00, 05/02, 06/03, 08/06, 08/07, 12/07, 12/08, 12/09, 12/10, 06/11, 08/11, 12/12, 04/14, 04/15, 02/16, 10/16, 01/17, 05/17 , 03/18, 07/18, 02/19, 03/20, 05/20, 04/21, 05/21, 11/21, 03/22, 02/23, 12/23, 02/24. 08/24, 03/25 (snm)
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Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:
Providence Health Plan and Providence Health Assurance
as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:
Commercial
Medicaid

POLICY CRITERIA:

COVERED USES:
Infertility and fertility preservation, subject to benefit limitations or criteria listed below. Refer to the applicable contract, member handbook or benefit summary for coverage questions.

REQUIRED MEDICAL INFORMATION:

1. For **fertility preservation**, preferred gonadotropins and Lupron® may be covered if the patient’s benefit covers fertility preservation, meeting one of the following scenarios:
    a. The patient’s benefit covers fertility preservation when due to treatment for cancer and the following criteria are met:
        i. The requested drug will be used for retrieval and storage of eggs and/or sperm
        ii. The patient will be undergoing treatment for cancer that is expected to cause irreversible infertility as recommended by evidence-based guidelines such as the National Comprehensive Cancer Network (NCCN),
    b. The patient’s benefit covers fertility preservation for those with sickle cell disease
    c. The patient’s benefit covers fertility preservation for any reason (such as egg/sperm storage)

2. For treatment of **infertility**, preferred gonadotropins and Lupron® may be covered if the patient's benefit covers the planned infertility treatment [such as intrauterine insemination (IUI) vs. in vitro fertilization (IVF)].
3. Non-preferred therapies may be covered when criteria 1 or 2 above are met and subject to the following criteria:
    a. For Gonal-F®: documented inadequate response, intolerance, or contraindication to Follistim AQ®
    b. For Ovidrel®: documented inadequate response, intolerance, or contraindication to Novarel®, Pregnyl®, or generic chorionic gonadotropin
    c. For Cetrotide®: documented inadequate response, intolerance, or contraindication to Fyremadel® or generic ganirelix acetate

EXCLUSION CRITERIA:
1. Hypogonadism, unrelated to infertility
2. Cryptorchidism

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

QUANTITY LIMIT:
Menopur®: Six 75-unit vials per day

COVERAGE DURATION:
Authorization will be approved for one year

Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage for Medicaid is limited to a condition that has been designated a covered line item number by the Oregon Health Services Commission listed on the Prioritized List of Health Care Services.

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCEND006	ENDOCRINE & METABOLIC DRUGS FERTILITY AND RELATED MEDICATIONS (See Table 1 for medications)

INTRODUCTION:

This policy refers to medications used to promote the ability to conceive and produce viable offspring. Human menopausal gonadotropin or hMG (Menopur®) is a medication often used for women who don't ovulate because of problems with their pituitary gland—hMG acts directly on the ovaries to stimulate development of mature eggs. Follicle-stimulating hormone or FSH (Gonal-F®; Follistim®) is a medication that works much like hMG. It stimulates development of mature eggs within the ovaries. Gonadotropin-releasing hormone (GnRH) analogs and GnRH antagonists (e.g., ganirelix) are medications that act on the pituitary gland to prevent a woman from ovulating. They are used during in vitro fertilization (IVF) cycles, or to help prepare a woman's uterus for an embryo transfer.

Chorionic gonadotropins, hCG, (Pregnyl®, Novarel®, Ovidrel®) stimulate the production of androgens.

Table 1. BILLING GUIDELINES AND CODING

Coding◊	Drug Product	Preparation
Preferred Products		
S0128, J3490	Follistim AQ® (follitropin β)	FSH
J0725	Generic chorionic gonadotropin	hCG
J0725	Pregnyl® (chorionic gonadotropin)	hCG
J0725	Novarel® (chorionic gonadotropin)	hCG
S0132, J3490	Fyremadel® (ganirelix acetate)/generic ganirelix acetate	GnRH antagonist
S0122, J3490	Menopur® (menotropins)	FSH/LH
Non-Preferred Products		
S0126, J3490	Gonal F® (follitropin α/β)	FSH
J0725	Ovidrel® (choriogonadotropin α)	hCG
J3490	Cetrotide® (cetrorelix acetate)	GnRH antagonist
Other therapies		
J1950	Lupron® (leuprolide)	GnRH analog
ADMINISTRATION◊		
96372	Ther/proph/diag inj sc/im	

◊ Coding/Administration Notes:

• The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.

• HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

POSITION STATEMENT:

The coverage of gonadotropins and Lupron® for fertility treatment is subject to the member's benefit. If the member has the benefit, they may be covered for ovulation induction therapy, intrauterine insemination, ovarian stimulation, or assisted reproductive technology (ART).

Fertility declines in women with increasing age, with age being a strong predictor of the potential for successful reproduction.[5] Other causes for infertility include ovulatory disorders, endometriosis, pelvic adhesions, tubal blockage, other tubal abnormalities, and hyperprolactinemia.

Fertility Treatment

- Ovarian Stimulation: Medications used for ovulation induction/promoting follicle development include Follistim AQ®, Gonal-F®, and Menopur®.
- Triggers for Ovulation: When the ovarian follicles are deemed to be mature, agents used to trigger ovulation include hCG and GNRH analogs, such as leuprolide.
- GNRH antagonists and GNRH analogs, such as leuprolide, are used to help prevent premature ovulation.
- GNRH analogs are used to help reduce the risk of ovarian hyperstimulation syndrome.

Cryptorchidism

- Also known as undescended testis (UDT), cryptorchidism is one of the more common genital disorders identified at birth for males. It is typically considered congenital (testes are undescended from birth) or acquired (testes were descended but then move to an undescended position later in life).
- The preferred treatment for undescended testes is surgery.
- Primary hormonal therapy with human chorionic gonadotropin has historically been used, though quality of evidence is low.
    - The action of hCG or LH is thought to stimulate production of androgens by the Leydig cells; however, the exact mechanism of action of increased androgens in stimulating testicular descent is not known.[1]
- American Urological Association (2014, reaffirmed 2018)[1]
    - Providers should not use hormonal therapy to induce testicular descent as evidence shows low response rates and lack of evidence for long-term efficacy. (Standard; Evidence Strength: Grade B).
    - In the absence of spontaneous testicular descent by six months (corrected for gestational age), specialists should perform surgery within the next year. (Standard; Evidence Strength: Grade B)
    - In prepubertal boys with palpable, cryptorchid testes, surgical specialists should perform scrotal or inguinal orchidopexy. (Standard; Evidence Strength: Grade B)

    - While it is optimal to perform surgery for the cryptorchid testis by 18 months of age, there are clear benefits to performing orchidopexy in all prepubertal boys at the time of diagnosis of a cryptorchid testis.
- Due to lack of quality evidence, treatment of cryptorchidism with gonadotropins is not considered medically necessary and will not be covered.

Male Factor Infertility

- Causes of male factor infertility include endocrine disorders such as hypogonadism (testosterone deficiency), sperm and sperm transport abnormalities, congenital or developmental disorders such as cryptorchidism, or idiopathic male fertility.
- American Urological Association/American Society for Reproductive Medicine (AUA/ASRM) Diagnosis and Treatment of Infertility in Men (2021)[2,6]:
    - Clinicians may use aromatase inhibitors (AIs), hCG, selective estrogen receptor modulators (SERMs), or a combination thereof for infertile men with low serum testosterone. (Conditional Recommendation; Evidence Level: Grade C)
    - For the male interested in current or future fertility, testosterone monotherapy should not be prescribed. (Clinical Principle)
    - For men with idiopathic infertility, a clinician may consider treatment using an FSH analogue with the aim of improving sperm concentration, pregnancy rate, and live birth rate. (Conditional Recommendation; Evidence Level: Grade B)
- American Urological Association (AUA) Evaluation and Management of Testosterone Deficiency (2018, reaffirmed 2024)[3]:
    - Exogenous testosterone has inhibitory effects on the production of intratesticular testosterone, which is imperative to maintain normal spermatogenesis. For this reason, alternative therapies, such as hCG are commonly used to promote the endogenous production of testosterone.
    - hCG should only be considered for patients with testosterone deficiency (formerly referred to as hypogonadism) desiring to maintain fertility.
    - Testosterone replacement is the treatment of choice for patients with testosterone deficiency. Therefore, hCG will not be covered for hypogonadism, unless related to infertility management and the member has the associated benefit.

REFERENCE/RESOURCES:

1. Kolon TF, Herndon CD, Baker LA, et al; American Urological Assocation. Evaluation and treatment of cryptorchidism (reaffirmed 2018): AUA guideline. J Urol. 2014 Aug;192(2):337-45. doi: 10.1016/j.juro.2014.05.005. Epub 2014 May 20. PMID: 24857650.
2. Schlegel PN, Sigman M, Collura B, et al. Diagnosis and treatment of infertility in men: AUA/ASRM guideline part I. Fertil Steril. 2021 Jan;115(1):54-61. doi: 10.1016/j.fertnstert.2020.11.015. Epub 2020 Dec 9. PMID: 33309062.
3. Mulhall JP, Trost LW, Brannigan RE et al: Evaluation and management of testosterone deficiency (reaffirmed 2024): AUA guideline. J Urol 2018; 200: 423.
4. Practice Committee of the American Society for Reproductive Medicine. Evidence-based treatments for couples with unexplained infertility: a guideline. Fertil Steril. 2020 Feb;113(2):305-322. doi: 10.1016/j.fertnstert.2019.10.014. PMID: 32106976.
5. American College of Obstetricians and Gynecologists Committee on Gynecologic Practice and Practice Committee. Female age-related fertility decline. Committee Opinion No. 589. Fertil Steril. 2014 Mar;101(3):633-4. doi: 10.1016/j.fertnstert.2013.12.032. PMID: 24559617.
6. Schlegel PN, Sigman M, Collura B, et al. Diagnosis and Treatment of Infertility in Men: AUA/ASRM Guideline PART II. J Urol. 2021 Jan;205(1):44-51. doi: 10.1097/JU.0000000000001520. Epub 2020 Dec 9. PMID: 33295258.