Pharmacy Management Drug Policy

SUBJECT: Infertility Medications
POLICY NUMBER: PHARMACY-24
EFFECTIVE DATE: 01/2003
LAST REVIEW DATE: 12/19/2024

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☐ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☐ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☐ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Infertility is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings.

The treatment of infertility may include a variety of diagnostic procedures, therapeutic drugs, and assistive reproductive technology (ART) procedures. This policy pertains to medications including, but not limited to, leuprolide, chorionic gonadotropins, follitropins, menotropins and gonadotropin-releasing hormone antagonists that would be used in conjunction with the appropriate diagnostic and ART procedures. Current medications under this policy include chorionic gonadotropin, Novarel, Pregnyl, Ovidrel, Gonal-f, Follistim AQ, Menopur, Cetrotide, Cetrorelix Acetate, Ganirelix, Fyremadel, Endometrin and leuprolide.

Artificial insemination, including IUI (intrauterine insemination), is where fertilization takes place within the human body. Assisted Reproductive Technologies (ART), including but not limited to IVF, GIFT or ZIFT, is where fertilization takes place outside the human body.

As of September 1, 2002, New York, State Law has mandated the following benefits for treatment of infertility, under most managed care and health insurance policies. *(Refer to the member's subscriber contract for the specific benefit effective date.)*

- Policies providing coverage for prescription drugs that also cover hospital or medical/surgical benefits must provide coverage for FDA approved drugs for the diagnosis and treatment of infertility, including the induction of pregnancy.
- In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), reversal of elective sterilization, sex change procedures, and cloning or medical/surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines are excluded from this mandate; thus, any medications used in conjunction with these procedures are also excluded from coverage under the mandate.
- "Iatrogenic infertility", which is defined as an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

- Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm.
- Large group policies that provide medical, major medical or similar comprehensive type coverage shall provide coverage for three cycles of in-vitro fertilization used in the treatment of infertility.
  - A cycle is defined as “either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.”
  - The three-cycle limit is a lifetime maximum of three cycles per enrollment with HealthPlan.

Pursuant to Circular Letter No. 3 (2021) issued by the New York State Department of Financial Services (“DFS”) on February 23, 2021, diagnostic and treatment services, including prescription drugs, for the diagnosis and treatment of infertility (“basic infertility treatments”) are required to be covered under individual, small group, and large group health insurance policies and contracts for individuals who are unable to conceive due to their sexual orientation or gender identity.

POLICY:

I. Based upon our criteria and assessment of the peer-reviewed literature, infertility medications have been medically proven to be effective and therefore medically appropriate in the treatment of infertility if the request meets *all* the following criteria:

1. The determination of appropriate candidates for the treatment of infertility and the identification of the required training, experience and other standards for health care providers who wish to diagnose and treat infertility must be in accordance with the standards and guidelines adopted by American College of Obstetrics and Gynecology (ACOG) **AND** American Society for Reproductive Medicine (ASRM) **AND**
2. The member must have a diagnosis of infertility characterized by:
   a. the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older, or
   b. Earlier evaluation and treatment may be warranted based on the member's medical history or physical findings.
   c. Coverage for basic infertility treatments will be provided for individuals who are unable to conceive due to their sexual orientation or gender identity.
3. For the induction of spermatogenesis with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure, the following applies:
   a. Coverage of follitropins (Gonal-f, Follistim) or menotropins (Menopur) require member must have a trial of hCG therapy alone for at least 3 months to normalize serum testosterone levels
   b. Coverage of follitropins (Gonal-f, Follistim) or menotropins (Menopur) require Provider attestation of normal serum testosterone levels (300 – 1,000ng/dL)
   c. Member must use follitropins (Gonal-f, Follistim) or menotropins (Menopur) in conjunction WITH hCG therapy
   d. Follitropins (Gonal-f, Follistim) or menotropins (Menopur) will be covered for males even if being used during an IVF cycle as increasing sperm count is independent of IVF status
   e. The recommended dose of hCG for males is 500u – 4000u IM 3x/wk and for Gonal-f is 150u – 300u AQ 3x/wk for up to 18 months.

f. Approval will be granted in 6-month intervals. Recertification will require Provider attestation of continued monitoring for the induction of spermatogenesis
g. Gonal-f & Follistim AQ are the only follitropins approved for use in males. The use of Menopur (menotropin) off-label will also be covered.

4. Medications to be used for standard fertility preservation (collecting, preserving, and storing of ova and sperm) will be covered:
   a. when a medical treatment may directly or indirectly cause "iatrogenic infertility", which is defined as an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes
      OR
   b. As specified in the member's benefit plan.
5. Medications used in conjunction with in-vitro fertilization in the treatment of infertility will be covered:
   a. For three cycles for members covered under large group policies that provide medical, major medical or similar comprehensive type coverage.
      i. A cycle is defined as "either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer."
      ii. The three-cycle limit is a lifetime maximum of three cycles per enrollment with HealthPlan.
      OR
   b. As specified in the member's benefit plan.
6. Medications used in conjunction with in-vitro fertilization or fertility preservation due to "iatrogenic infertility", when IVF limits have not been exceeded, are covered, subject to prior authorization requirements, regardless of whether the HealthPlan member has drug coverage under his/her policy. Coverage for any other uses is excluded for members who do not have drug coverage under his/her policy.
7. Step therapy applies: All requests for Follistim AQ must have a trial and failure of Gonal-f first

II. The following fertility products will be subject to quantity limits:

Drug Name	Strength/Form			Limits per month		Actual Unit Limit/month (based on package size)	Quantity Limit (mLs)
Follistim AQ	300	IU/0.36mL	Cartridge	12	Cartridges	3600	5
Follistim AQ	600	IU/0.72mL	Cartridge	6	Cartridges	3600	5
Follistim AQ	900	IU/1.08mL	Cartridge	4	Cartridges	3600	5
Gonal-f	450	IU/mL	M-D vial	10	M-D vials	4500	10
Gonal-f	1050	IU/mL	M-D vial	4	M-D vials	4200	4
Gonal-f RFF	75	IU/mL	PFS	47	Prefilled Syringes	3525	47
Gonal-f RFF	300	IU/0.5 mL	Pen/Rediject	15	Pens	4500	7.5
Gonal-f RFF	450	IU/0.75mL	Pen/Rediject	10	Pens	4500	7.5
Gonal-f RFF	900	IU/1.5 mL	Pen/Rediject	5	Pens	4500	7.5
Chorionic gonadotropin	10,000	Unit	Vial	6	Vials	60,000	-
Novarel	5,000	Unit	Vial	12	Vials	60,000	-

Novarel	10,000	Unit	Vial	6	Vials	60,000	-
Pregnyl	10,000	Unit	Vial	6	Vials	60,000	-

POLICY GUIDELINES:

1. The plan does not discriminate based on a member's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status, or gender identification.
2. Clinical Review criteria related to gender dysphoria has been reviewed and approved by the New York State Office of Mental Health.
3. Utilization Management are contract dependent and coverage criteria may be dependent on the contract renewal date. Additionally, coverage of drugs listed in this policy are contract dependent. Refer to specific contract/benefit language for exclusions
4. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drug(s) is the only criterion that is not met for a given condition, and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required.
    - The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the member;
    - The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
    - The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
    - The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
    - The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rational for deeming stability as it relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
    - The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.
5. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference the Coverage Exception Evaluation Policy for All Lines of Business Formularies policy for review guidelines.
6. Approval duration will be for:
    a. 6 months for induction of ovulation
    b. 6 months for the induction of spermatogenesis with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure
7. Clinical documentation must be submitted for each request (initial and recertification) unless otherwise specified (e.g., provider attestation required). Supporting documentation includes, but is not limited to, progress notes documenting previous treatments/treatment history, diagnostic testing, laboratory test

results, genetic testing/biomarker results, imaging and other objective or subjective measures of benefit which support continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations.

- Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition.

8. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32).

UPDATES:

Date:	Revision:
12/19/2024	Revised
09/13/2024	Revised
08/15/2024	Reviewed & Approved P&T Committee
07/31/2024	Revised
12/06/2023	Revised
09/11/2023	Revised
08/24/2023	Reviewed & Approved P&T Committee
04/2023	Revised
12/2022	Revised
11/2022	Revised
10/2022	Revised
9/2022	Revised/P&T Committee Approval
11/19/2021	Revised
10/2021	Revised
9/2021	Review/P&T Committee Approval
04/2021	Revised
11/2020	Review
09/2020	P&T Approval
11/19	Revision
09/19	Revision
11/18	Revision
10/18	Review
08/18	Revision
10/17	Revision
7/16	Revision
5/16	Revision
2/16	Revision
7/15	Review
8/14	Revision
8/13	Revision
2/11	Revision
3/10	Revision

9/09	Review
11/8	Revision
9/8	Revision
1/03	Created

REFERENCES:

1. New York State Insurance Law §3221 and §4303- Infertility Mandate, effective September 1,2002.
2. New York State Insurance Department Opinion regarding Coverage for Infertility Medications, November 8, 2005
3. Centers for Disease Control and prevention website - http://www.cdc.gov/art/ accessed online July 2015
4. Follistim AQ Cartridge Product Information. Merck & Co., Inc. Aug 2011 Revised 12/2014 accessed online July 2015
5. Gonal-f RFF pen Prescribing Information EMD Serono, Inc. Revised 12/2011 accessed online July 2015
6. Sauer, MV et al. Comparative efficacy and safety of cerrorelix with or without midcycle recombinant LH and leuprolide acetate for inhibition of premature LH surges in assisted reproduction. Reproductive Healthcare. 2004 Nov. 9(5), 487-93.
7. Cetrotide prescribing information. EMD Serono, Inc. February 2008 Revised 01/2014 accessed online July 2015
8. Ovidrel prescribing information. EMD Serono, Inc. June 2010 Revised 11/2014 accessed online July 2015
9. Bravelle prescribing information Ferring Pharmaceuticals Inc., August 2007 Revised 02/2014 accessed online July 2015
10. Novarel prescribing information Ferring Pharmaceuticals Inc., Revised 07/2012 accessed online July 2015
11. Ganirelix prescribing information Merck & Co., INC., Revised 12/2013 accessed online July 2015
12. Menopur prescribing information Ferring Pharmaceuticals Inc., Revised February 2014 accessed online July 2015
13. Pregnyl prescribing information Organon USA Inc., April 2011 Revised 01/2015 accessed online July 2015
14. Dickey, RP et al. Comparison of the efficacy and safety of a highly purified human follicle- stimulating hormone (Bravelle) and recombinant follitropin-beta for in vitro fertilization: a prospective, randomized study. Fertil Steril. 2002 Jun;77(6):1202-8.
15. Williams, RS et al. Pregnancy rates in varying age groups after in vitro fertilization: a comparison of follitropin alfa (Gonal F) and follitropin beta (Follistim) Am J Obstet Gynecol. 2003 Aug;189(2):342-6; discussion 346-7.
16. Lamb JD et al Follicle-stimulating hormone administered at the time of human chorionic gonadotropin trigger improves oocyte developmental competence in in vitro fertilization cycles: a randomized, double-blind, placebo-controlled trial Fertil Steril. 2011 Apr;95(5):1655-60
17. Schertz JC et al. The redesigned follitropin alfa pen injector: results of the patient and nurse human factors usability testing Expert Opin Drug Deliv. 2011 Sep;8(9):1111-20. doi: 10.1517/17425247.2011.608350. Epub 2011 Aug 16
18. Practice Committee of the American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertility and Sterility. Vol. 99, No. 1, January 2013. https://www.fertstert.org/article/S0015-0282(12)02242-X/pdf
19. Dorland's Illustrated Medical Dictionary. 29th Edition. Philadelphia: Saunders; 2000.
20. New York State Department of Financial Services. Insurance Circular Letter No.7 (2017). Re: Health Insurance Coverage for Infertility Treatment Regardless of Sexual Orientation or Marital Status. Accessed online: https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Final_Infertility_CL_4.19.17.pdf
21. New York State Department of Financial Services. Report on In-Vitro Fertilization and
22. Fertilization Preservation Coverage. February 27, 2019. Accessed online: https://www.dfs.ny.gov/system/files/documents/2019/02/dfs_ivf_report_02272019.pdf
23. New York State 2019-2020 Budget. Accessed online: https://assembly.ny.gov/2019budget/budget/A2007c.pdf
24. New York State Department of Financial Services. Insurance Circular Letter No. 3 (2021). Accessed online: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_03