

Policy Name: Infertility Medications - Illinois**Policy #:** 1376P

Purpose of the Policy

The purpose of this policy is to provide guidelines for coverage of infertility prescription drugs for members in Illinois.

Statement of the Policy

Prescription drugs for the treatment of infertility require prior authorization from the Health Alliance Pharmacy Department. Infertility agents include clomiphene citrate, Bravelle, Cetrotide, Chorionic gonadotropin (human), Follistim, Ganirelix, Gonal-F, leuprolide sub-q, Menopur, Novarel, Ovidrel, Pregnyl, Repronex, and Delestrogen.

Federal employees and self-funded plans have specific coverage that may differ from the State of Illinois mandated services below.

Illinois law states, "If the (member's) policy does not contain a prescription drug benefit, it must establish one solely for coverage of prescription drug therapies for infertility."

Procedures

1. Prescription drugs for treatment of infertility will be covered if the member has been approved for infertility services by the Utilization Management (UM) department.

- 1.1 If an approval for infertility treatment from the UM department is on file, the requested drugs will be approved for the durations indicated in Section 3.
- 1.2 If an approval for infertility treatment from the UM department is **not** on file, the Pharmacy department will notify the provider that an authorization is required and direct the provider to fax the request to the UM department at (217) 902-9771.
- 1.3 If a **denial** of infertility treatment from the UM department is on file, the Pharmacy department will send a letter of denial for the prescription drugs to the member and the provider.
- 1.4 Authorization requests for infertility medications that are not being used for infertility are reviewed by the Pharmacy department and do not require review by Utilization Management

2. Gonadotropin-releasing hormone agonists (GnRHs) for fertility preservation

- 2.1 Illinois law requires medically necessary expenses for standard fertility preservation services are covered when a necessary medical treatment may directly or indirectly cause iatrogenic infertility
 - *Iatrogenic infertility: an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment that affects reproductive organs or processes.*
- 2.2 GnRHs are medically necessary for fertility preservation if a request indicates the presence of the following:
 - Premenopausal state
 - Presence of an intact female reproductive system
 - Chart notes or a statement from the provider explaining why freezing of eggs or embryos is not feasible
 - Diagnosis of breast cancer
 - Approval time: 12 months
 - Reapproval: 12 months, if gonadotoxic (fertility damaging) treatment is continued.

3. Approval Periods

- 3.1 With basic or enhanced infertility approval from Utilization Management on file:

- Clomiphene: The earlier of 12 months or through the end of the infertility authorization.
 - Injectable Agents: The earlier of 6 months or through the end of the infertility authorization.
- 3.2 IVF/FET (in vitro fertilization/frozen embryo transfer)
- An enhanced infertility authorization will be on file, but if provider states that the member is doing IVF or FET, then an IVF or FET authorization is also required
 - Injectable agents: The earlier of 3 months or through the end of the IVF/FET authorization approved by the UM department.
- 3.3 If a member has an approval on file for enhanced infertility, but has an IVF/FET authorization currently under review, the UM department will verify if member is eligible for coverage of requested medications at that time.

CPT Codes

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HCPCS Codes

J0725	Injection, chorionic gonadotropin, per 1,000 USP units
J1380	Injection, estradiol valerate, up to 10 mg
J3355	Injection, urofollitropin, 75 IU
J3490	Unclassified drugs
J8499	Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU
X5622	Chorionic gonadotropin (HCG) – 1,000 units/ml

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. 215 Illinois Comp. Stat. 5/356m (2016). Infertility Coverage.
<https://www.ilga.gov/legislation/publicacts/fulltext.asp?name=102-0170&GA=102&SessionId=110&DocTypeId=HB&DocNum=3709&GAID=16&SpecSess=0&Session=>
2. 215 Illinois Comp. Stat. 5/356z.32 (2019). Coverage for fertility preservation services.
<https://www.ilga.gov/legislation/ilcs/documents/021500050K356z.32.htm>

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DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.