Drug Coverage Policy

Effective Date.....7/15/2026
Coverage Policy Number.....IP0800
Policy Title.....Follitropins

Infertility – Follitropins

- Gonal-f®, Gonal-f® RFF, Gonal-f® RFF Redi-ject (follitropin alfa injection – EMD Serono)
- Follistim® AQ (follitropin beta injection – Organon)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

The Gonal-f products and Follistim AQ are gonadotropins (follicle stimulating hormones [FSH]).[1-5] The Gonal-f products and Follistim AQ are indicated for the induction of **ovulation and pregnancy in the anovulatory infertile patient**, in whom the cause of infertility is functional and not due to primary ovarian failure. The Gonal-f products are also indicated for the development of multiple follicles in ovulatory patients participating in an assisted reproductive technology (ART) program.[1-3] Follistim AQ is also indicated in normal ovulatory women undergoing controlled ovarian stimulation as part of an *in vitro* fertilization or intracytoplasmic sperm injection cycle.[4] Gonal-f (but not Gonal-f RFF) and Follistim AQ are also indicated for the induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure.[1-4] Clomiphene citrate tablets are indicated for the treatment of **ovulatory dysfunction in women who desire pregnancy**.[5]

Guidelines
American Society for Reproductive Medicine (ASRM) committee opinion (2020) on the use of exogenous gonadotropins for ovulation induction in anovulatory women note that gonadotropin therapy has more risks than oral ovulation induction.[7] The publication states that gonadotropin therapy should only be used by clinicians who have the training and experience to use these products. Most women will respond to ovulation induction with oral medications, but exogenous gonadotropin treatment may be an option in women who fail to respond to lifestyle modifications and oral agents. The ASRM opinion states that there is no significant advantage to using any specific gonadotropin preparation.

An international evidence-based guideline for the management of PCOS was released in 2023.[6] The guideline recommends that letrozole should be the first-line pharmacological treatment in women with PCOS and anovulatory infertility without other infertility factors. Both metformin and clomiphene could be used in women with PCOS with anovulatory infertility and no other infertility factors. Gonadotropins (e.g., FSH) alone could be considered rather than clomiphene citrate therapy. Gonadotropins could also be second-line pharmacological therapy for women with PCOS who have failed first-line oral ovulation induction therapy and are anovulatory and infertile with no other infertility factors. Gonadotropins could also be considered rather than the combination of clomiphene citrate and metformin in patients who are clomiphene resistant. These guidelines additionally state there appears to be no difference in the clinical efficacy of gonadotropins preparations.

Coverage Policy

Coverage of treatment services for infertility varies across plans. Please refer to the related coverage policy (0089 Infertility Services).

Policy Statement
Injectable fertility medications are specifically excluded under most benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

Prior Authorization is required for benefit coverage of follitropins. In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression. All approvals are provided for the duration noted below.

Follitropins are considered medically necessary when ONE of the following is met (I or II):

I. Gonal-f, Gonal-f RFF, Gonal-f RFF Redi-ject. Approve for 1 year if the patient meets the following (1):

FDA-Approved Indications

1. **Infertility.** Patient meets ONE of the following (A, B, or C):
   A. *Females undergoing infertility treatment, use is for ovulation induction; OR
   B. *Females undergoing fertility preservation, use is for ovulation induction; OR
   C. *Males, use is for the treatment of hypogonadotropic hypogonadism.

II. Follistim AQ. Approve for 1 year if the patient meets the following (1 and 2):

FDA-Approved Indications

1. **Infertility.** Patient meets ONE of the following (A, B, or C):
   A. *Females undergoing infertility treatment, use is for ovulation induction; OR
   B. *Females undergoing fertility preservation, use is for ovulation induction; OR
   C. *Males, use is for the treatment of hypogonadotropic hypogonadism.
2. Preferred product criteria is met for the product(s) as listed in the below table(s).

Employer Plans and Individual and Family Plans:

Product	Criteria
Follistim AQ	**1.** Approve if the patient meets ONE of the following (A or B): **A)** Approve for 1 year if the patient meets ONE of the following (i or ii): **i.** Patient has tried ONE of the following: Gonal-f, Gonal-f RFF, or Gonal-f RFF Redi-ject; OR **ii.** *Males, patient already started on treatment with Follistim AQ for the induction of spermatogenesis in patients with primary or secondary hypogonadism; OR. **B)** *Females, patient already started on a cycle of treatment with Follistim AQ: approve for the duration needed to complete the current cycle.

*Refer to the Policy Statement.

Conditions Not Covered

Follitropins for any other use is considered not medically necessary. Criteria will be updated as new published data are available.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU

References

1. Gonal-f multi-dose vials [prescribing information]. Boston, MA: EMD Serono; March 2025.
2. Gonal-f RFF vial [prescribing information]. Rockland, MA: EMD Serono; November 2023.
3. Gonal-f RFF Redi-ject pens [prescribing information]. Boston, MA: EMD Serono; March 2025.
4. Follistim AQ Cartridge [prescribing information]. Jersey City, NJ: Organon; July 2023.
5. Clomid tablets [prescribing information]. South Plainfield, NJ: Cosette; August 2023.
6. Recommendations from the 2023 International Evidence Based Guideline for the assessment and management of polycystic ovary syndrome. *J Clin Endocrinol Metab.* 2023;108(10):2447-2469.
7. Use of exogenous gonadotropins for ovulation induction in anovulatory women: a committee opinion. American Society for Reproductive Medicine. *Fertil Steril*. 2020;113(1):66-70.

Revision Details

Summary of Changes	Review Date	Effective Date
New policy. **Coding Information:** **Added** S0126 and S0128	5/14/2026	7/15/2026

The policy effective date is in force until updated or retired.