BlueCross BlueShield
Federal Employee Program

ART / Infertility / Gender Dysphoria

Bravelle (urofollitropin)
Cetrotide (cetrorelix)
Clomiphene citrate, Clomiphene powder
Crinone, Endometrin, Progesterone in oil, Progesterone powder, Prometrium (progesterone)
Follistim AQ (follitropin beta)
Fyremadel/Ganirelix (ganirelix)
Gonal-F, Gonal-F RFF (follitropin alfa)
Menopur (menotropins)
Milprosa* (progesterone)

*This medication is included in this policy but is not available on the market as of yet

Pre - PA Allowance

The drugs addressed by this policy are covered without a Prior Authorization (PA) for all female patients over 50 years of age.

Prior-Approval Requirements

The drugs addressed by this policy *are covered without a Prior Authorization (PA) for all female patients over 50 years of age.*

Diagnoses

Female

ALL diagnoses are covered **EXCEPT:**

Patients must **NOT** use for the following indication:

1. Used in conjunction with assisted reproductive technology (ART) procedures, which include but are not limited to:
    a. Artificial insemination (AI)
    b. In vitro fertilization (IVF)
    c. Embryo transfer and gamete intrafallopian transfer (GIFT)
    d. Zygote intrafallopian transfer (ZIFT)
    e. Intravaginal insemination (IVI)
    f. Intracervical insemination (ICI)
    g. Intracytoplasmic sperm injection (ICSI)
    h. Intrauterine insemination (IUI)

Male

ALL diagnoses are covered **EXCEPT:**

For the following indication patient must have:

1. Hypogonadotropic hypogonadism with **ALL** of the following:

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a. **NOT** caused by primary testicular failure
b. Patient has low pretreatment testosterone levels
c. Patient has low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels
d. Used for spermatogenesis

AND NOT used for the following for both males and females:

1. Weight loss
2. Anti-aging effects
3. Performance (athletic) enhancement
4. Erectile or sexual dysfunction

Diagnosis

The patient must have the following:

Gender Dysphoria (GD)

1. Prescribed by an endocrinologist or transgender specialist
2. Patient has met the DSM V criteria for GD

Prior - Approval Limits

Duration	Females	6 months
	Males	12 months
	GD	2 years

Prior – Approval *Renewal* Requirements

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Diagnoses

Female

ALL diagnoses are covered **EXCEPT:**

Patients must **NOT** use for the following indication:

1. Use in conjunction with assisted reproductive technology (ART) procedures, which include but are not limited to:
    a. Artificial insemination (AI)
    b. In vitro fertilization (IVF)
    c. Embryo transfer and gamete intrafallopian transfer (GIFT)
    d. Zygote intrafallopian transfer (ZIFT)
    e. Intravaginal insemination (IVI)
    f. Intracervical insemination (ICI)
    g. Intracytoplasmic sperm injection (ICSI)
    h. Intrauterine insemination (IUI)

Male

ALL diagnoses are covered **EXCEPT:**

For the following indication patient must have:

1. Hypogonadotropic hypogonadism with **ALL** of the following:
    a. **NOT** caused by primary testicular failure
    b. Patient has low pretreatment testosterone levels
    c. Patient has low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels
    d. Used for spermatogenesis

AND NOT used for the following for both males and females:

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3. Performance (athletic) enhancement
4. Erectile or sexual dysfunction

Diagnosis

The patient must have the following:

Gender Dysphoria (GD)

1. Prescribed by an endocrinologist or transgender specialist

Prior - Approval *Renewal* Limits

Same as above