Human Menopausal Gonadotropins (hMG)

Policy Number: PHARMACY 288.8 T2
Effective Date: September 1, 2020

Coverage Rationale

Oxford has engaged Optum to perform reviews of requests for prior authorization (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals). All prior authorization requests are handled by Optum. To obtain prior authorization for a procedure related to the treatment of infertility, please call Optum at 877-512-9340.

This policy refers to the following hMG agent:
• Menopur® (menotropins for injection)

The clinically appropriate dosing for hMG when used in an ART cycle without an FSH product is 450 IU/day or less for not more than 14 days of treatment. The total dose of gonadotropin (hMG and FSH) should not exceed 450 IU per day when used in any mixed stimulation protocol. When used as part of a mixed stimulation protocol (hMG + FSH) or when used alone for ovulation induction or controlled ovarian stimulation the clinically appropriate maximum dosing for hMG agents is 150 IU/day. Exceeding this daily dose and duration of treatment has not been proven to be efficacious in terms of pregnancy outcome.

hMG agents will be referred to as “gonadotropins” in the following medical necessity language.

In absence of a product listed and in addition to applicable criteria outlined within the drug policy, prescribing and dosing information from the package insert is the clinical information used to determine benefit coverage.

The following information pertains to medical necessity review:

General Requirements (applicable to all medical necessity requests): 3,4,20,32

For initial and continuation of therapy, ALL of the following must be met for consideration of treatment:
• Prognosis for conception must be ≥ 5%; and
• Adequate ovarian reserve as indicated but not limited to at least one the following markers (one or more of the following within the previous 6 months):
  o FSH level < 15 mIU/ml if > 35 years of age; or
Diagnosis-Specific Requirements

The information below indicates additional requirements for those indications having specific medical necessity criteria in the list of proven indications.

hMG gonadotropins are proven and medically necessary for:

**Ovulation Induction**

Gonadotropins are proven and medically necessary for the treatment of ovulatory dysfunction when ALL of the following criteria are met:

- Failure to ovulate with both Clomid (clomiphene citrate) and Femara (letrozole);* and
- One of the following:
  - Anovulation; or
  - Oligo-ovulation; or
  - Both of the following:
    - Amenorrhea; and
    - Other specific causative factors (e.g., thyroid disease, hyperprolactinemia) have been excluded or treated; and
- One of the following:
  - For assisted reproductive technologies (ART), dose does not exceed 450 IU/day, for no more than 14 days per cycle;
  - or
  - For ovulation induction, dose does not exceed 225 IU/day, for no more than 14 days per cycle.

* PCOS, anovulatory or oligo-ovulatory patients who fail to ovulate with clomiphene after dosage adjustment up to 150 mg per day should attempt ovulation induction with letrozole before proceeding to gonadotropins. Patients diagnosed with hypothalamic amenorrhea (failure to withdraw to progesterone) who demonstrate hypoestrogenemia may move directly to gonadotropins.

Gonadotropins are unproven and not medically necessary for the treatment of ovulatory dysfunction in the following situations:

- Beyond the 6th gonadotropin induced ovulatory cycle
- When there are ≥ 4 follicles which are ≥ 15 mm in diameter from a previously gonadotropin-induced ovulation, despite a dosage adjustment (e.g., doses of gonadotropin down to 37.5 IU per day)
- When used alone for individuals with unexplained infertility
- When there is a failure to respond to ovulation stimulation (e.g., doses of gonadotropins up to 225 IU per day and no follicles ≥ 15 mm in diameter)
- In lieu of clomiphene or letrozole to correct a thin endometrial lining
- An estradiol level < 100 pg/ml/follicle ≥ 15 mm in diameter
- Doses that exceed 450 IU/day for ART or 225 IU/day for ovulation induction, respectively
- Duration of therapy that exceeds 14 days per cycle; a longer than 14-day stimulation may be considered in the setting of hypothalamic amenorrhea

**Controlled Ovarian Stimulation**

Gonadotropins are proven and medically necessary for the treatment of controlled ovarian stimulation when ALL of the following criteria are met:

- Used alone or in conjunction with intrauterine insemination (IUI); and
- One of the following:
  o Treatment in individuals with diminished ovarian reserve that have not responded to clomiphene or letrozole; or
  o Initial treatment for individuals with diminished ovarian reserve; or
  o Treatment for individuals ≥ 40 years of age in conjunction with ART; or
  o In the setting of unilateral proximal tubal disease in conjunction with IUI when there is no evidence of tubal compromise on the patent side when at least 2 cycles of oral agents (clomiphene or letrozole) have failed to yield a dominant follicle on the side with a patent fallopian tube and
- One of the following:
  o For assisted reproductive technologies (ART), total gonadotropin dose does not exceed 450 IU/day, for no more than 14 days per cycle; or
  o For controlled ovulation stimulation, dose does not exceed 150 IU/day, for no more than 14 days per cycle.

Gonadotropins are unproven and not medically necessary for the treatment of controlled ovarian stimulation in the following situations:\textsuperscript{32}
- Treatment in individuals with unexplained infertility, endometriosis, bilateral tubal factor infertility, recurrent pregnancy loss, male factor infertility\textsuperscript{19,20}
- In lieu of clomiphene or letrozole to correct a thin endometrial lining\textsuperscript{28,31}
- When there is a failure to respond to ovarian stimulation (e.g., doses of gonadotropins up to 150 IU per day and no follicles ≥ 15 mm in diameter)
- An estradiol level < 100 pg/ml/follicle ≥ 15 mm in diameter
- When there are ≥ 4 follicles which are ≥ 15 mm in diameter from a previously gonadotropin-induced ovulation, despite a dosage adjustment.
- Following ART cycles that fail to result in conception due to poor ovarian response or poor-quality oocytes or embryos
- Doses that exceed 450 IU/day for ART or 150 IU/day for controlled ovulation stimulation, respectively
- Duration of therapy that exceeds 14 days per cycle
- Beyond 4 cycles for individuals age < 38, 2 cycles for individuals age 38-39, individuals > 40 years of age without ART
- In the setting of very poor/futile prognosis, defined as a FSH level ≥ 15 mIU/ml if ≥ 40 years of age or FSH level ≥ 20 mIU/ml if < 40 years of age

**Hypogonadotropic Hypogonadism**

Gonadotropins are proven and medically necessary for the treatment of hypogonadotropic hypogonadism when ALL of the following criteria are met:
- One of the following:
  o Diagnosis of primary hypogonadotropic hypogonadism; or
  o Diagnosis of secondary hypogonadotropic hypogonadism and
- For the induction of spermatogenesis; and
- Infertility is not due to primary testicular failure.

**Prior Authorization Requirements**

Prior authorization through Optum is required in all sites of service.

**Applicable Codes**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.
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<td>Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle</td>
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**Benefit Considerations**

Some Certificates of Coverage and some Oxford Health Plan pharmacy riders contain an explicit exclusion for infertility treatments, including infertility drugs. The member specific benefit plan document must be used to adjudicate infertility benefits.

Some states mandate benefit coverage for infertility treatments, including infertility drugs. These mandates may vary from state to state. Oxford Health Plans follows these mandates, where applicable.

Some Certificates of Coverage allow coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy.

Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Administrative Policy titled: [Acquired Rare Disease Drug Therapy Exception Process](#).

**Clinical Evidence**

**Proven/Medically Necessary**

The Menopur in GnRH Antagonist Cycles with Single Embryo Transfer (MEGASET) study compared the efficacy and safety of highly purified menopausal gonadotropin (hMG) and recombinant follicle stimulating hormone (rFSH) for controlled ovarian stimulation in gonadotropin releasing hormone (GnRH) antagonist cycle with compulsory single-blastocyst transfer was examined in a multicenter, randomized, open-label, assessor-blind, parallel-group, noninferiority trial. The trial recruited 810 and randomized 749 women aged 21 to 34 years with a BMI of 18 to 25 kg/m2 with a primary diagnosis of infertility being unexplained infertility or mild male factor, among additional inclusion criteria. Women were recruited through 25 infertility centers in seven countries. On day 2 to 3 of the menstrual cycle, patients were randomized in a 1:1 ratio to treatment with hMG (Menopur, n = 374) or rFSH (follitropin beta; Puregon, n = 375). Starting doses for each gonadotropin was fixed at 150 IU for the first 5 days. From stimulation day 6 and on, dosing could be changed by 75 IU per adjustment and no more frequently than every 4 days and a maximum dose of 375 IU daily for a maximum of 20 days. Ganirelix acetate (Orgalutran) was initiated on day 6 as well, 0.25mg daily, and continued through the stimulation period. A single injection of 250 mcg human chorionic gonadotropin (hCG) (choriogonadotropin alpha, Ovitrelle) was injected to induce final follicular maturation when 3 follicles of ≥ 17 mm were observed. The target for ovarian stimulation was to obtain 8 to 10 oocytes. The cycle was cancelled in case of fewer than three follicles with a diameter ≥ 12 mm on day 14 of stimulation or more than 25 follicles with a diameter of ≥ 10 mm. Luteal phase support treatment was with vaginal progesterone capsules (600mg/day) from the day after oocyte retrieval to day 13 to 15 after embryo transfer. The primary endpoint was ongoing pregnancy rate, live birth weights, as well as
pharmacodynamic parameters. Noninferiority was to be documented for both the intention-to-treat (ITT) population (all randomized and exposed patients, n = 749), and the per-protocol (PP) population (all randomized and exposed, except those excluded due to protocol violations, n = 676). The PP population included 676 patients (343 for hMG and 333 for rFSH). After 5 days of stimulation, serum FSH concentration was significantly higher (p<0.001) in the hMG group than the rFSH group, and more follicles ≥ 12mm (p=0.011) as well as higher levels of serum estrogen (p=0.003) and inhibin B (p<0.001) detected on day 6 of stimulation in the rFSH group than the hMG group. Mean levels of progesterone on day 6 were higher with rFSH (p=0.25) than with hMG. At the end of stimulation, no significant differences between groups were noted in the number of follicles ≥ 17mm or 15 to 16 mm, but significantly (p=0.24) more follicles with a diameter of 12 to 14 mm were observed in the rFSH group. Serum concentrations of FSH, LH, and estrogen at the end of stimulation were significantly higher (p<0.001) in the hMG group. For 97% of the treatment population oocyte retrieval was performed. Excessive response caused cancellation of therapy in only two rFSH patients and none in the hMG group. The number of oocytes retrieved was significantly higher (p<0.001) in the rFSH group, but no significant differences between groups in the percentage of metaphase II oocytes or fertilization rate. Significantly (p=0.005) more embryos on day 3 in the rFSH group, but the number of blastocysts on day 5 were not significantly different between groups. Both groups had similar cleavage rate, embryo quality on day 3, blastocyst quality on day 5, and percentage of patients with blastocysts on day 5 (82% hMG and 85% rFSH), and patients with at least one surplus frozen blastocyst (55% and 57%, respectively. Embryo transfer was performed for 82% and 84% of the hMG group and rFSH group patients, respectively. The ongoing pregnancy rate per started cycle was 30% with hMG and 27% with rFSH for the PP population and 29% and 27% respectively, for the ITT population. The treatment difference in ongoing pregnancy rates was 3.0% (95% CI -3.8 to 9.8) and 2.2% (95% CI -4.2 to 8.6) for the PP and ITT populations, respectively, both in favor of hMG. The lower limit of the 95% CI for this difference was well above the pre-established noninferiority margin of -10% for both the PP and ITT populations. The live birth rate after the fresh cycle was 29% with hMG and 26% with rFSH for PP and 28% and 26%, respectively, for the ITT populations. A total of 116 patients (31%) in the hMG group and 122 (33%) in the rFSH group had blastocysts thawed, of whom 107 (29%) and 115 (31%), respectively, had blastocyst transfer in a frozen cycle. The 1-year cumulative ongoing pregnancy rate per patient was 41% for hMG and 39% rFSH for PP population and 40% and 39%, respectively, for the ITT population. The cumulative live birth rate was 40% after hMG and 38% after rFSH for both PP and ITT populations. The overall incidence of adverse events during the fresh cycle was similar for the two treatments, with 39% in the hMG group and 37% in the rFSH group with at least 1 adverse event. OHSS was experienced by 3% (10 patients) in each treatment group. Overall the MEGASET trial establishes evidence that hMG is at least as effective as rFSH in GnRH antagonist cycles with compulsory single-blastocyst transfer.

A multicenter, randomized, open-label, parallel group study compared the efficacy and safety of subcutaneous (SC) and intramuscular (IM) Repronex (menotropins for injection) and Pergonal (menotropins for injection) IM in patients undergoing ovulation induction.23 115 infertile, premenopausal, anovulatory, or oligo-ovulatory, nonsmoking women between 18 and 30 years of age, with a BMI < 38, were recruited from 10 academic and private infertility clinics. Patients meeting inclusion criteria underwent pituitary down-regulation with leuprolide acetate 1 mg/d SC, continued unchanged until the day prior to hCG was administered. Patients who were unsuccessful with down-regulation were removed from the trial. Patients were then randomized into one of three treatment groups: Repronex SC (n=36), Repronex IM (n=36), or Pergonal IM (n=36), 450 IU day 1, then 225 IU daily for the next 4 days. The protocol was amended to 150 IU daily for the first 5 days, followed by individualized daily dosing (max 12 days total), after 4 of the first 6 patients experienced high day 5 estrogen levels and/or excessive multifollicular development. At day 6, investigators adjusted the daily dose upward by 75 to 150 IU (no more frequent than every other day) to a maximum daily dose of 450 IU. When patients had at least one follicle with a mean diameter of ≥ 14 mm and appropriate estrogen levels, a single dose of 10,000 USP units of hCG was administered. Patients who did not have adequate follicular growth or appropriate serum estrogen levels after 12 days of stimulation were considered treatment failures and did not receive hCG and therapy was cancelled. Therapy was also cancelled if the patient was at risk for OHSS or high orders multiple gestation. After hCG administration, patients were instructed on timed intercourse or IUI was performed. Progesterone vaginal gel was permitted for luteal phase support.

Gociel et al., compared the efficacy and safety of Repronex SC, IM and Pergonal IM in patient undergoing in vitro fertilization (IVF) in a multicenter, randomized, open-label, parallel-group study.24 The trial recruited 189 premenopausal women with regular ovulatory menstrual cycles undergoing IVF for infertility attributable to tubal factors, endometriosis (stage I or II), or unknown factors. Qualifying patients received leuprolide acetate, 1mg SC daily beginning 7 days before the anticipated onset of menses and continued until the day before hCG was administered and serum estrogen levels were appropriate. If menses did not occur within 20 days after beginning leuprolide treatment or serum estrogen levels were not ≤ 40 pg/mL, then the treatment was stopped. Three patients did not meet criteria to continue the trial. Patients (n = 186) were then randomized to receive either Repronex SC or IM (225 IU daily, n = 60 or n = 65, respectively) or Pergonal IM (225 IU daily, n = 61) for 5 consecutive days.
Menotropin response was reassessed on day 6, where, based on follicle size and serum estrogen levels, the investigators adjusted the doses. Investigators then adjusted the doses upward by 75 to 150 IU/day, no more frequently than every other day. Stimulation was continued until the subject met criteria for hCG administration (one follicle ≥ 17 mm or 2 to 3 follicles ≥ 15 mm). Subjects meeting hCG criteria received 5,000 IU hCG subcutaneously to trigger ovulation. Subjects then underwent UIU or had sexual intercourse. The ovulation rate for the per-protocol (PP) population was 85.7% for the hMG group and 85.5% for the rFSH group. For the intent-to-treat population (ITT), the ovulation rate was 83.5% and 84.9% for the hMG and rFSH groups, respectively. Non-inferiority of hMG versus rFSH with respect to ovulation rate was demonstrated with a margin of -11.0% and -12.0% for the PP and ITT populations, respectively. In the ITT population, subjects in the hMG group had on average significantly fewer intermediate-sized follicles (12 – 16 mm) after stimulation versus the rFSH group (1.04 and 1.91, respectively, p = 0.009), but no difference between groups in the mean number of follicles ≥ 17 mm. Development of a single dominant follicle was achieved for 63.7% in the hMG group versus 54.8% in the rFSH group. The median treatment duration was 13 days in the hMG group versus 11 days in the rFSH group. The median threshold dose was 75 IU in both groups. There was no significant difference in the number or rate of OHSS or cycle cancellation (2.2% with hMG and 9.8% rFSH, p = 0.058). Treatment outcomes of clinical and ongoing pregnancy rates were also similar between groups. The live birth rate was 14.3% and 15.1% with the hMG and rFSH groups, respectively. The frequency of adverse events was similar in the two treatment groups (41.3% hMG and 402% rFSH) with a similar adverse event profile. The authors concluded that gonadotropin simulation with hMG is at least as efficacious as rFSH in anovulatory WHO Group II women resistant to clomiphene citrate.

**Technical Assessments**

A 2019 Cochrane review was published comparing the effectiveness and safety of gonadotropins as a second-line treatment for ovulation induction in women with clomiphene citrate-resistant polycystic ovary syndrome (PCOS), and women who do not ovulate or conceive after clomiphene citrate. The review included 15 trials with 2387 women. Ten trials compared rFSH with urinary-derived gonadotropins (three compared rFSH with human menopausal gonadotropin, and seven compared rFSH with FSH-HP), four trials compared FSH-P with hMG. There were no trials that compared FSH-HP with FSH-P. One trial compared FSH with continued clomiphene citrate. The authors concluded that there may be little or no difference in live birth, incidence of multiple pregnancy, clinical pregnancy rate, or miscarriage rate between urinary-derived gonadotropins and recombinant.
follicle stimulating hormone in women with polycystic ovary syndrome. For human menopausal gonadotropin or highly purified human menopausal gonadotropin versus urinary follicle stimulating hormone it is uncertain whether one or the other improves or lowers live birth, incidence of multiple pregnancy, clinical pregnancy rate, or miscarriage rate. It is uncertain whether any of the interventions reduce the incidence of ovarian hyperstimulation syndrome. It is suggested to weigh costs and convenience in the decision to use one or the other gonadotropin. In women with clomiphene citrate failure, gonadotropins resulted in more live births than continued clomiphene citrate without increasing multiple pregnancies.

A 2011 Cochrane review was published which compared the effectiveness of recombinant FSH (rFSH) with the three main types of urinary gonadotropins (hMG, purified FSH, and highly purified FSH) for ovarian stimulation in women undergoing IVF and ICSI treatment cycles. With the analysis of 42 trials with a total of 9,606 couples, the authors concluded that:

- Comparing rFSH to all other gonadotropins combined, irrespective of down-regulation protocol used, did not result in any evidence of a statistically significant difference in live birth rate (28 trials, 7,339 couples, odds ratio (OR) 0.97, 95% CI 0.87 to 1.08).
  - Suggests that for a group with a 25% live birth rate using urinary gonadotropins, the rate would be between 22.5% and 26.5% using rFSH.
- Comparing rFSH to all other gonadotropins combined, there was no evidence of a difference in the OHSS rate (32 trials, 7,740 couples, OR 1.18, 95% CI 0.86 to 1.61).
  - Suggests that for a group with a 2% risk of OHSS using urinary gonadotropins, the risk would be between 1.7% and 3.2% with rFSH.
- When considering different urinary gonadotropins separately, there were significantly fewer live births after rFSH than hMG (11 trials, N=3,197, OR 0.84, 95% CI 0.72 to 0.99).
  - Suggests that for a live birth rate of 25% using HMG, use of rFSH instead would be expected to result in a rate between 19% and 25%.
- No evidence of a difference in live births when rFSH was compared with purified FSH (5 trials, N=1,430, OR 1.26, 95% CI 0.96 to 1.64) or compared to highly purified FSH (13 trials, N=2,712, OR 1.03, 95% IC 0.86 to 1.22).
- All available gonadotropins are equally effective and safe. The choice of product will depend on the availability, convenience, and associated costs.

**Hypogonadotropic Hypogonadism**

A prospective, open-label, intent to treat study of 21 men, with a diagnosis of hypogonadotropic hypogonadism, evaluated the efficacy of gonadotropin treatment in stimulating spermatogenesis. Six of the 21 men had normal puberty, followed by the onset of hypogonadism, 2 of which had previously fathered children. The 15 remaining men failed to undergo normal pubertal development, 7 of which had cryptorchidism and treated by orchiopexy in childhood. Fourteen normal men were recruited for pretreatment gonadal comparison to the study group but were not subsequently treated. Study participants were initially treated with human chorionic gonadotropin (hCG) 2,000 IU every Monday, Wednesday, and Friday, which produced normal serum testosterone levels within two months in 18 of the patients. One subject required 4,000 IU, another 5,000 IU, and a third only required 1,250 IU of hCG at the same frequency. If the sperm count did not increase to within the lower limit for normal men (≥43 million per ejaculate) after the serum testosterone was normal for six months, the men were started on human menopausal gonadotropins (hMG). The dose given was 75 IU every Monday, Wednesday, and Friday, for the first 4 months and 150 IU at the same frequency for the following four months. Prior to the study, all men had low testosterone levels and only two men had any detectable sperm count. Five patients had normal follicle-stimulating hormone (FSH). During hCG treatment phase, the total sperm count increased to within the normal range in all 6 patients in whom hypogonadism had occurred after puberty, but only 1 in 15 in whom it had occurred before puberty (p<0.002). hMG was then added with 14 patients whom sperm counts did not respond to hCG alone, but whose serum testosterone remained normal. The sperm count increased to within normal limits in 5 of the 7 men with prepubertal onset of hypogonadism but not history of cryptorchidism, but only 1 of 7 men with prepubertal onset of hypogonadism and history of cryptorchidism. The mean maximum sperm count of the 13 men whose counts were within the normal range, treated with hMG, was 86 million, less than the mean of the 14 normal men (154 million). Of the 13 men whose sperm counts became normal, 8 of them were able to conceive, 6 during the protocol period, 2 during an extension period. Only 1 patient was able to conceive whose sperm count did not reach the normal range. In all, 14 pregnancies occurred in nine wives. All patients except one had maximal sperm counts in proximity to the time they conceived. Five other men who achieved normal sperm counts did not conceive. Four did not continue the treatment regimen after the study and one patient’s wife refuse evaluation. The authors conclude that hMG treatment will usually increase sperm count to normal in men with hypogonadotropic hypogonadism, unless cryptorchidism has occurred. The need for hMG treatment depends on the time of onset of hypogonadism.
In 2012, the European Association of Urology published guidelines for male infertility. These guidelines included the treatment recommendations for hypogonadotropic hypogonadism. The guidelines state that hypogonadotropic hypogonadism can be treated medically. The standard treatment is hCG, with the later addition of hMG or recombinant FSH, depending on initial testicular volume. In some cases of idiopathic hypogonadotropic hypogonadism, spontaneous reversibility of reproductive function has been observed.

**Menopur®** is a preparation of gonadotropins (FSH and LH activity), extracted from the urine of postmenopausal women, which has undergone additional steps for purification.

Menopur® is a sterile, lyophilized powder intended for subcutaneous (SC) injection after reconstitution with sterile 0.9% Sodium Chloride Injection, USP. Each vial of Menopur® contains 75 International Units of follicle-stimulating hormone (FSH) activity and 75 International Units of luteinizing hormone (LH) activity, plus 21 mg lactose monohydrate and 0.005 mg Polysorbate 20 and Sodium Phosphate Buffer (Sodium Phosphate Dibasic, Heptahydrate and Phosphoric Acid). The biological activity of Menopur® is determined using the bioassays for FSH (ovarian weight gain assay in female rats) and LH (seminal vesicle weight gain assay in male rats), modified to increase the accuracy and reproducibility of these assays. The FSH and LH activity assays are standardized using the Fourth International Standard for Urinary FSH and Urinary LH, November 2000, by the Expert Committee on Biological Standardization of the World Health Organization (WHO ECBS). Both FSH and LH are glycoproteins that are acidic and water soluble. Human Chorionic Gonadotropin (hCG) is detected in Menopur®.

Menopur®, administered for 7 to 20 days, produces ovarian follicular growth and maturation in women who do not have primary ovarian failure. Treatment with Menopur® in most instances results only in follicular growth and maturation. When sufficient follicular maturation has occurred, hCG must be given to induce ovulation.

Human menopausal gonadotropin (hMG) is also used for induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure.

The American Society for Reproductive Medicine (ASRM) defines infertility as a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years. It affects about 10% to 15% of couples.

In addition to age, other factors that influence fertility include lifestyle (smoking, alcohol, caffeine, drugs, and body mass index) and the timing and frequency of intercourse. Normal sperm can survive at least 3 days, but an oocyte can be fertilized for only 12 to 24 hours.

The major causes of infertility include tubal and peritoneal pathology (30% - 40%), ovulatory dysfunction (15%), and male factor (30% - 40%). Uterine and cervical factors are uncommon. Patients without an identifiable cause are classified as unexplained infertility (10%).

Human menopausal gonadotropin (hMG) is needed in women for the growth and development of follicles in the ovaries. Follicles are small round sacs that contain the egg cells. In women, the level of FSH is critical for the onset and duration of follicular development, and consequently for the timing and number of follicles reaching maturity.

hMG therapy is used for the development of more eggs when participating in an assisted reproductive technology (ART) program, such as in vitro fertilization.
References


### Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

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