

**Follitropins**  
**Follistim AQ (follitropin beta)**  
**Gonal-F (follitropin alfa)**  
**Gonal-F RFF (follitropin alfa)**  
**Effective 01/01/2024**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Medical Benefit</b> <b>Pharmacy Benefit</b>	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
<b>Exceptions</b>			

#### Overview

N/A

#### Coverage Guidelines

##### **Ovulation induction or follicle stimulation as part of an assisted reproductive technology (ART) program**

Authorization may be granted for members when ANY of the following criteria is met, and documentation is provided:

1. Member has completed three or more previous cycles of clomiphene.
2. Member has a risk factor for poor ovarian response to clomiphene.
3. Member has contraindication or exclusion to clomiphene.
4. Member is 37 years of age or older.

##### **Hypogonadotropic hypogonadism**

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. Member has low pretreatment testosterone levels.
2. Member has low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels.

##### **For Follistim AQ (follitropin beta) only**

Authorization may be granted for members when ANY of the following criteria is met in addition to the criteria above, and documentation is provided:

1. Member has a contraindication to Gonal-F or Gonal-F RFF or any of its drug components.
2. Member is intolerant to or had a confirmed adverse event with Gonal-F or Gonal-F RFF.

#### Continuation of Therapy

Reauthorization may be granted for members when ALL initial authorization criteria are met.

#### **Limitations**

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company.

1. Authorizations will be granted for 12 months

## References

N/A

## Review History

06/27/05 – Reviewed

08/15/05 – Effective

04/24/06 – Reviewed

04/23/07 – Reviewed

04/28/08 – Reviewed and revised

04/27/09 – Reviewed

04/26/10 – Reviewed

04/25/11 – Reviewed

04/23/12 – Reviewed in P&T Meeting

02/27/17 – Reviewed and revised (adopted SGM & ST)

06/26/18 – Reviewed and revised in P&T Meeting.

11/15/2023 – Reviewed and Updated for Nov P&T; Removed Bravelle as product is no longer available. Added Gonal-F RFF as a preferred agent along with Gonal-F. Effective 1/1/24

