**Drug Name:** Human Chorionic Gonadotropin and Ovidrel (choriogonadotropin alfa)

**Date:** 7-2018

| **Drug Name:** | **Human Chorionic Gonadotropin and Ovidrel (choriogonadotropin alfa)** |
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| **Prescriber Restrictions:** | n/a |
| **Inclusion Criteria:** | **The member must have one of the following indications:**<br><br>**FDA-Approved Indications**<br>**Human Chorionic Gonadotropin is indicated for:**<br>• Prepubertal cryptorchidism not due to anatomic obstruction<br>• Selected cases of hypogonadotropic hypogonadism (hypogonadism secondary to a pituitary deficiency) in males<br>• Induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure, and who has been appropriately pretreated with human menotropins<br><br>**Ovidrel is indicated for:**<br>• Induction of final follicular maturation and early luteinization in infertile women who have undergone pituitary desensitization and who have been appropriately pretreated with follicle stimulating hormones as part of an assisted reproductive technology (ART) program such as in vitro fertilization and embryo transfer<br>• Induction of ovulation and pregnancy in anovulatory infertile patients in whom the cause of infertility is functional and not due to primary ovarian failure<br><br>**Compendial Uses**<br>• Prepubertal cryptorchidism<br>• Hypogonadotropic hypogonadism in males<br>• Infertility, luteal phase support<br><br>**All other indications are considered experimental/investigational and are not a covered benefit.** |
| **Required Medical Information:** | **(Approve if meets one of the following)**<br>• **Induction of oocyte maturation and/or release, OR**<br>• **Prepubertal cryptorchidism, OR**<br>• **Hypogonadotropic hypogonadism and has**<br>  ○ Low pretreatment testosterone levels AND<br>  ○ Low or low-normal follicle stimulating hormone (FSH) or luteinizing hormone (LH) levels |
| **Note(s):** | Coverage review will be bypassed for drug(s) being requested for a procedure that has been approved under a member's medical benefit plan. |
| **Coverage duration:** | • **Induction of oocyte maturation and/or release and Hypogonadotropic hypogonadism: Approve for 12 months**<br>• **Prepubertal cryptorchidism: Approve for 6 months** |