

**Coverage of any drug intervention discussed in the plans prior authorization guideline is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.**

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Commercial (Small & Large Group)       ASO       Exchange/ACA  
 Medicare Advantage (MAPD)

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**FERTILITY MEDICATIONS**

**PA1942**

**Covered Service:**    Yes

**Prior Authorization Required:**    Yes

**Additional Information:**    Must be prescribed by a Reproductive Specialist with prior authorization through Navitus.

**Medicare Policy:**    Prior authorization is not required for Medicare Cost products (Dean Care Gold) and Medicare Supplement (Select) when this drug is provided by participating providers. Prior authorization is required if a member has Medicare primary and the plan secondary coverage. This policy is not applicable to our Medicare Replacement products.

**Wisconsin Medicaid Policy**    Coverage of prescription drug benefits is administered by the Wisconsin Medicaid program. Coverage of medical drug benefits is administered by the Wisconsin Medicaid fee-for-service program. Medical drugs not paid on a fee-for-service basis by the Wisconsin Medicaid program are covered by the plan with no PA required.

**Plan Approved Criteria (approved for up to 12 months, subject to formulary and benefit changes):**

- 1.0 Member has a primary diagnosis of infertility; and
- 2.0 The requested medication is NOT prescribed for artificial reproductive technology.

**Comment(s):**

- 1.0 **NOTE: The use of physician samples or manufacturer discounts does not guarantee later coverage under the provisions of the medical certificate and/or**

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**pharmacy benefit. All criteria must be met in order to obtain coverage of the listed drug product.**

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