Effective Date **12/1/2022**
Next Review Date… **12/1/2023**
Coverage Policy Number **IP0492**

Clomiphene

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Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for Clomiphene.

Coverage for fertility services may be excluded under certain benefit plans. Please review benefit plan for details of specific coverage, including quantity or cycle limitations.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Clomiphene is considered medically necessary when the following are met:

1. **Ovulatory Dysfunction.** Individual meets **ONE** of the following criteria (A or B):
   A. As part of an Assisted Reproductive Technology (ART) program
   B. Oligoovulatory or anovulatory infertile woman in whom the cause of infertility is functional and not due to primary ovarian failure

Reauthorization Criteria

Not applicable for continuation beyond initial approval duration.

Authorization Duration

Initial approval duration: up to 6 months
Reauthorization approval duration: not applicable

Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

1. **Male Infertility**
   Clomiphene is not indicated for the treatment of male infertility.[1]

Background

OVERVIEW
Clomiphene citrate tablets are indicated for the treatment of ovulatory dysfunction in women desiring pregnancy.[1] Patients most likely to achieve success with clomiphene therapy include patients with polycystic ovarian syndrome (PCOS), amenorrhea-galactorrhea syndrome, psychogenic amenorrhea, post-oral contraceptive amenorrhea, and certain cases of secondary amenorrhea of undetermined etiology.

References

1. Clomiphene Citrate Tablets [prescribing information]. Chestnut Ridge, NY: Par; May 2021.