



Drug Coverage Policy

Effective Date 12/1/2025
Coverage Policy NumberIP0333
**Policy Title..... Gonadotropin-
Releasing Hormone Antagonists**

Infertility – Gonadotropin-Releasing Hormone Antagonists

- Cetrotide® (cetrotorelix acetate subcutaneous injection – EMD Serono, generics)
- Ganirelix (ganirelix acetate subcutaneous injection – Organon; generics)
- Fyremadel® (ganirelix acetate subcutaneous injection – Ferring; generic only)

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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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

Cetrotide (brand and generic), Ganirelix (brand and generic), and Fyremadel (generic only) are indicated for the **inhibition of premature luteinizing hormone (LH) surges** in women undergoing controlled ovarian stimulation.¹⁻³

Cetrotide, Ganirelix, and Fyremadel are synthetic decapeptides that are analogs of native gonadotropin-releasing hormone (GnRH) with GnRH antagonist activity.¹⁻³ GnRH induces the production and release of LH and follicle stimulating hormone (FSH) from the anterior pituitary. Both agents compete with natural GnRH for binding to membrane receptors on pituitary cells and control the release of LH and FSH in a reversible manner.

Injectable fertility medications are specifically excluded under most benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

The use of injectable fertility medications for the treatment of gender dysphoria is addressed in a separate coverage policy. Please refer to the related coverage policy link above (Treatment of Gender Dysphoria).

Coverage Policy

Gonadotropin-Releasing Hormones (GnRH) Antagonists (Cetrorelix acetate, Cetrotide, Fyremadel, ganirelix acetate) for Infertility Use are considered medically necessary when the following are met:

1. **Infertility.** Approve for 1 year if the patient meets BOTH the following criteria:
 - A. Inhibition of premature luteinizing hormone (LH) surges in a woman undergoing controlled ovarian stimulation (COS) in conjunction with assisted reproductive procedures
 - B. Preferred product criteria is met for the products listed in the below table

Individual and Family Plans:

Product	Criteria
Cetrotide injection (cetrorelix acetate 0.25 mg injection)	<ol style="list-style-type: none">1. Approve if the patient meets EITHER of the following (A or B):<ol style="list-style-type: none">A. Patient has tried the generic product cetrorelix acetate 0.25 mg injections AND cannot continue to use due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/ or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.B. Approve to complete the current cycle if the patient has been started on a current cycle of therapy with Cetrotide.

Conditions Not Covered

Gonadotropin-Releasing Hormones (GnRH) Antagonists (Cetrorelix acetate, Cetrotide, Fyremadel, ganirelix acetate) are considered experimental, investigational or unproven for **ANY** other infertility use.

Coding Information

Note:

- 1) This list of codes may not be all-inclusive.
- 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J3490 [†]	Unclassified drugs
S0132	Injection, ganirelix acetate, 250 mcg

[†]Note: May be considered for coverage when used to report Cetrotide[®]

References

1. Cetrotide[®] subcutaneous injection [prescribing information]. Rockland, MA: EMD Serono; June 2024.
2. Ganirelix acetate subcutaneous injection [prescribing information]. Jersey City, NJ: Organon ; February 2024.
3. Fyremadel[®] (ganirelix acetate subcutaneous injection) [prescribing information]. Parsippany, NJ: Ferring; November 2024.
4. Clinical Pharmacology [database online]. Elsevier Inc.; 2025. Available at: Clinical Pharmacology Home. Accessed on September 12, 2025. Search terms: cetrotirelix.
5. Micromedex[®] Healthcare Series. Thomson Reuters (Healthcare) Inc. Available at: Home - MICROMEDEX. Accessed on September 12, 2025. Search terms: cetrotirelix.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	No criteria changes.	12/15/2024
Annual Revision	Updated policy title from "Gonadotropin-Releasing Hormone (GnRH) Antagonists for Infertility Use" to "Infertility – Gonadotropin-Releasing Hormone Antagonists." Updated Individual and Family Plans Preferred Product Criteria for brand Cetrotide.	12/1/2025

The policy effective date is in force until updated or retired.

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth

