

FERTILITY MANAGEMENT

1. SUMMARY OF MAJOR CHANGES: This directive includes the following changes:

a. Paragraph 2: Adds responsibilities for the Under Secretary for Health; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer; Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer; Assistant Under Secretary for Health for Integrated Veteran Care; Assistant Under Secretary for Health for Operations; Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer; Executive Director, National Center for Ethics in Health Care; Executive Director, Pharmacy Benefits Management Services; and Veterans Integrated Service Network (VISN) Chief Medical Officer.

b. Paragraph 2: Adds requirement to create VISN- and Department of Veterans Affairs (VA) medical facility-led Fertility Interdisciplinary Teams.

c. Paragraph 3: Expands storage of fertility preservation from gametes to include gonadal tissue and previously created embryos for medical indication and increases coverage from 5 to 10 years.

d. Paragraph 3: Clarifies language for obtaining fertility medications.

e. Paragraph 4: Adds training recommendations through the Talent Management System.

f. Paragraph 7: Adds definitions for beneficiary, embryo, female, fertility counseling, genetic testing, gonadal tissue, intersex, male and pregnancy options counseling; removes definitions for fecundability and preconception care.

g. Removes former Appendix A, Assessment, Counseling and Treatment, and former Appendix B, Patient Resources on Infertility Services; adds new Appendix A, Comparison of VHA Directives 1332 and 1334 by Eligibility Group, and Appendix B, Fertility Preservation for Medical Indication.

2. RELATED ISSUES: VHA Directive 1334(1), In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses, dated March 12, 2021; VHA Directive 1341(3), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018; VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

3. POLICY OWNER: The Office of Women's Health (10W) is responsible for the contents of this Veterans Health Administration (VHA) directive. Questions may be referred to the Director, Reproductive Health at

VHACOReproductiveHealthTeam@va.gov.

4. LOCAL DOCUMENT REQUIREMENTS: There are no local document creation requirements in this directive.

5. RESCISSIONS: VHA Directive 1332(2), Fertility Evaluation and Treatment, dated June 20, 2017, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of May 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

7. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Shereef Elhanal, MD, MBA
Under Secretary for Health

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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COMPARISON OF VHA DIRECTIVES 1332 AND 1334 BY ELIGIBILITY GROUP.....A-1

APPENDIX B

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FERTILITY MANAGEMENT

1. POLICY

It is Veterans Health Administration (VHA) policy to provide fertility evaluation, management and select treatment for fertility-related conditions to Veterans and other eligible beneficiaries, regardless of service connection, sexual orientation, gender identity, gender expression, relationship status or marital status. **NOTE:** *The Department of Veterans Affairs (VA) cannot authorize in vitro fertilization (IVF) under the medical benefits package, 38 C.F.R. § 17.38, as it is specifically excluded therein. A separate legislative provision, 38 C.F.R. § 17.380, may apply to certain Veterans who have a service-connected condition, or treatment thereof, that results in their inability to procreate without the use of fertility treatment. Veterans who meet specific criteria may be eligible for assisted reproductive technology (ART), including IVF, authorized by VHA. The spouses of those Veterans may be eligible for fertility services, counseling and treatment included in the medical benefits package as well as ART/IVF under 38 C.F.R. § 17.412. For additional information, see VHA Directive 1334(1), In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses, dated March 12, 2021. AUTHORITY: 38 U.S.C. §§ 1710, 1781(b), 7301(b), 38 C.F.R. §§ 17.270-17.279, 17.37, 17.38, 17.380 and 17.412.*

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer.** The Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer is responsible for supporting the VHA Office of Women's Health (OWH) with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for supporting Patient Care Services program offices with implementation of this directive and providing clinical practice oversight and support as appropriate.

d. **Assistant Under Secretary for Health for Integrated Veteran Care.** The Assistant Under Secretary for Health for Integrated Veteran Care (IVC) is responsible for:

(1) Assisting with VA medical facility-level, Veterans Integrated Service Network (VISN)-level and national program office-level consultation as needed or requested, including, but not limited to, ensuring Office of Community Care (OCC) participation in VISN- and VA medical facility-led Fertility Interdisciplinary Teams (IDTs); issues with access, claims and standardized episodes of care; and second-level review of the appeals process. For additional information about the VISN- and VA medical facility-led Fertility IDTs, see

<https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(2) Ensuring that eligible beneficiaries have access to fertility care throughout the VA health care system. Such care may be provided by VA medical facilities or through other programs, including but not limited to academic affiliations, sharing agreements or authorized care in the community.

(3) Ensuring that processes are in place to facilitate appropriate communication between authorized community care providers and applicable local offices (e.g., VA medical facility OCC) and appropriate staff.

(4) Developing education and training materials in collaboration with OWH to assist VISNs and VA medical facilities with implementation of this directive. **NOTE:** For training recommendations, see paragraph 4.

e. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the VISNs.

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

f. **Director, Reproductive Health, Office of Women's Health.** The Director, Reproductive Health, OWH is responsible for:

(1) Developing national policy and procedures for all fertility management services based on relevant laws, regulations and VHA's mission, goals and objectives. **NOTE:** For further information on fertility counseling and treatment under VA's special legislative authority, see VHA Directive 1334(1). For further information on perinatal care coordination, see VHA Directive 1330.03, Maternity Health Care and Coordination, dated November 3, 2020. For further information on abortion, see <https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Abortion.aspx>. This is an internal VA website that is not available to the public.

(2) Providing consultation, technical assistance, data review, ad hoc site visits and implementation guidance to VISNs and VA medical facilities. **NOTE:** Data are reviewed and reported to Congress on an annual basis and otherwise as needed.

(3) Developing recommendations for process improvement based upon review of clinical and administrative data and research findings provided by academic affiliates, and sharing these recommendations with VISN and VA medical facility programs for information and implementation.

(4) Developing education and training materials in collaboration with IVC to assist VISNs and VA medical facilities with implementation of this directive. **NOTE:** For training recommendations, see paragraph 4.

(5) Developing and disseminating public-facing educational materials explaining the fertility management benefits provided by VHA.

g. **Executive Director, Office of Nursing Services/Deputy Chief Nursing Officer.** The Executive Director, Office of Nursing Services/Deputy CNO is responsible for fostering ongoing collaboration and communication between nurse leaders and relevant VA stakeholders to support fertility management for all beneficiaries.

h. **Executive Director, National Center for Ethics in Health Care.** The Executive Director, National Center for Ethics in Health Care (NCEHC) is responsible for supporting VA medical facilities and OWH to provide ethics consultation in cases of fertility evaluation and treatment.

i. **Executive Director, Pharmacy Benefits Management Services.** The Executive Director, Pharmacy Benefits Management Services is responsible for providing policy and guidance for VHA's formulary management process and general pharmacy service requirements. **NOTE:** For further information, see VHA Directive 1108.08, VHA Formulary Management Process, dated July 29, 2022, and VHA Directive 1108.07(1), General Pharmacy Service Requirements, dated November 28, 2022. These directives define the responsibilities for VA medical facilities to provide prescription fulfillment services for medications, including fertility management medications.

j. **Veterans Integrated Service Network Director.** The VISN Director is responsible for ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

k. **Veterans Integrated Service Network Chief Medical Officer.** **NOTE:** The VISN Chief Medical Officer may delegate responsibilities to a designee. The VISN Chief Medical Officer is responsible for:

(1) Establishing and leading the VISN-led Fertility IDT. **NOTE:** For additional information about the operations and requirements of the VISN-led Fertility IDT, see <https://dva.gov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. This is an internal VA website that is not available to the public.

(2) Ensuring that VA medical facilities within the VISN comply with fertility service process improvement recommendations from OWH and IVC.

l. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(2) Ensuring processes are in place as described in paragraph 3.a. to determine eligibility for fertility services and communicate eligibility to the beneficiary.

(3) Ensuring that VA medical facility processes are developed for utilization review of fertility care in order to avoid under- or over-treatment or treatment limitations

(4) Establishing and leading a VA medical facility-led Fertility IDT if there are at least 10 beneficiaries seeking fertility counseling and treatment per year. If there are fewer than 10 beneficiaries per year, the VA medical facility must defer to the VISN-led Fertility IDT. **NOTE:** For additional information about the operations and requirements of the VA medical facility-led Fertility IDT, see <https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. This is an internal VA website that is not available to the public. Required tasks of the VA medical facility-led Fertility IDT include:

(a) Reviewing all fertility consults for eligibility and approval in a timely manner appropriate to the circumstances of each patient.

(b) Supporting fertility consults as needed (e.g., fertility preservation for medical indication; ovulation induction and ovarian stimulation medication for beneficiaries using timed intercourse, intrauterine insemination (IUI) or self-paid or third party-paid IVF).

(c) Overseeing the fertility consult.

(d) Maintaining bidirectional communication with the beneficiary.

(e) Documenting previous fertility care (e.g., six cycles of IUI per pregnancy).

(f) Renewing the consult after 1 year.

(g) Placing cryopreservation storage consults, including fertility preservation for medical indication, and conducting annual renewal of every cryopreservation consult.

(h) Tracking cryopreservation utilization, including number and location of specimens per beneficiary and time limits.

(5) Ensuring that processes are in place to support delivery of fertility management services and care coordination. For additional information, see <https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(6) Ensuring the VA medical facility implements the process improvement recommendations provided by OWH.

m. **VA Medical Facility Chief of Staff**. The VA medical facility Chief of Staff is responsible for:

(1) Ensuring that when questions arise regarding treatment because standards of care for fertility services are unavailable or unclear, VA health care providers consult with the Fertility IDT at the VA medical facility or VISN.

(2) Ensuring that when irresolvable conflicts arise between the VA health care provider, the beneficiary or the beneficiary's family regarding ethically justifiable decisions or actions about evaluation, management and treatment of fertility, such conflicts are resolved in an appropriate and timely manner consistent with the requirements in paragraph 3.b.(4) regarding operational requirements, assessment and treatment and irresolvable conflict.

(3) Ensuring that adequate staffing is provided for all care coordination (in accordance with VHA Directive 1110.04(1), Integrated Case Management Standards Of Practice, dated September 6, 2019) and utilization review needs involving fertility care for beneficiaries, including the identification of support staff to perform these duties and not assigning them as collateral duties of the Women Veterans Program Manager (in accordance with VHA Directive 1330.02, Women Veterans Program Manager (WVMP), dated August 10, 2018) or VA health care provider.

(4) Ensuring that beneficiaries who are found to be ineligible for fertility services (e.g., a beneficiary with azoospermia or who reached the maximum of six cycles of IUI per pregnancy) receive appropriate written information about the denial of services as well as information about the appeals process for these decisions. For guidance on notifying the beneficiaries of the appeals process, see VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020

n. **Chief, VA Medical Facility Office of Community Care.** The Chief, VA medical facility OCC is responsible for:

(1) Ensuring that coverage authorization and limitations as described in this directive are communicated to the VA-authorized community care provider and to the beneficiary.

(2) Ensuring that the care coordination system, including timely tracking of care, is properly employed to avoid under or over-treatment or treatment limitations.

(3) Communicating to the beneficiary at least 1 year in advance of the expiration of the cryopreservation benefit, except in the case of a death of a Veteran, which requires communication to next of kin within 1 month after the notification of death of the Veteran is received. **NOTE:** *For further information, see paragraph 3 on implementation and termination of benefits for fertility preservation for medical indication.*

o. **VA Medical Facility Chief of Pharmacy.** The VA medical facility Chief of Pharmacy is responsible for ensuring processes are in place to enable provision of formulary medications and approval and provision of non-formulary medications, including evidence-supported compounded fertility medications, that are prescribed by authorized fertility providers in the community.

p. **VA Health Care Providers.** VA health care providers, including social workers, pharmacists, nurses and other clinicians, are responsible for:

(1) Maintaining awareness of the fertility benefits available to all beneficiaries regardless of marital or relationship status, sex, sexual orientation or gender identity under the medical benefits package and fertility benefits available to those who meet eligibility criteria for fertility counseling and treatment under VA's special legislative authority. VA health care providers must understand how to connect beneficiaries to fertility services for which they are eligible.

(2) Providing fertility and family planning care within their respective area of practice and in accordance with generally accepted standards of medical practice and VA regulations. **NOTE:** *If the beneficiary requires resources or more specialized fertility care than can be provided by VA, the VA health care provider must place an appropriate request for community care fertility authorization(s).*

3. OPERATIONAL REQUIREMENTS

a. **Eligibility.**

(1) Veterans who are eligible to receive health care under the medical benefits package (38 C.F.R. § 17.38), or as otherwise authorized by 38 C.F.R. § 17.37, may receive VA-covered fertility evaluation, management, and treatment.

(2) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) allows VA to share the costs of fertility services and treatment to certain family members of Veterans (subject to exclusions) under 38 C.F.R. §§ 17.270-17.279. For detailed information regarding CHAMPVA benefits, see www.va.gov/COMMUNITYCARE/programs/dependents/champva/index.asp. **NOTE:** *CHAMPVA is not eligible for services under traditional community care authority. There is no VA referral to the community.*

(3) Through the CHAMPVA In-house Treatment Initiative (CITI) under 38 U.S.C. § 1781(b), participating VA medical facilities may provide medical services and supplies, subject to availability of space and resources, to CITI beneficiaries, excluding those with Medicare. See www.va.gov/COMMUNITYCARE/programs/dependents/champva/CITI.asp for more information.

(4) When VA is providing or authorizing fertility evaluation and treatment to an eligible person, and that eligible person's non-eligible partner is also pursuing fertility evaluation and treatment, both parties must be informed by appropriate staff, as determined locally, that payment for services for the non-eligible partner is their responsibility. These requirements must be communicated before any course of treatment for the eligible individual is undertaken.

b. **Assessment and Treatment.** VHA provides fertility management in accordance with generally accepted standards of medical practice, including but not limited to those

described at

<https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(1) **Infertility.** Infertility is a disease, condition, or status characterized by any of the following:

(a) The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

(b) The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.

(c) In patients having regularly occurring, unprotected intercourse with a partner with opposite-sex gametes and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the partner with a uterus and ovaries is under 35 years of age and at 6 months when that partner is 35 years of age or older.

(2) If medical standards are unavailable or unclear, VA health care providers must consult with the Fertility IDT at the VA medical facility or VISN-level.

(3) If medical standards remain unavailable or unclear after consultation with the Fertility IDT, then VA health care providers must consult with the following national program offices for guidance: OWH, IVC, Spinal Cord Injuries and Disorders (SCI/D), NCEHC or the National Surgery Office (NSO) and its Urology or Gynecology Surgical Advisory Board as clinically indicated.

(4) Should an irresolvable conflict arise between the VA health care provider, the beneficiary or their family regarding ethically justifiable decisions or actions about evaluation, management and treatment of fertility, a consult must be placed to the VA medical facility Health Care Ethics Consultation Service.

(5) If the beneficiary has concerns about clinical decisions related to fertility services, they must be made aware of the appeals process, which is outlined in VHA Directive 1041.

c. Fertility Preservation for Medical Indication. Gamete retrieval, cryopreservation (sperm, oocytes or ovarian tissue) and storage for a medical indication is allowed when it is determined by appropriate VA health care providers that gonadotoxic therapies (including chemotherapy, radiation, and surgery) are needed for a condition which would reasonably be expected to alter the functioning of gonads (testes, ovaries) and render the individual infertile, in order to promote, preserve or restore the health of the individual in accordance with generally accepted standards of medical practice (e.g., for oncofertility with cryopreservation of gametes to preserve fertility prior to cancer treatment which would ordinarily significantly impact the Veteran's future fertility; for

gender-affirming medical interventions for transgender, gender-diverse and intersex Veterans that affects ovarian and testicular function and fertility potential; see VHA Directive 1341(3), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018. See also Appendix B for additional information regarding fertility preservation for medical indication).

(1) Cryopreserved sperm, oocytes and ovarian tissue can be thawed or rewarmed to be used for future family building. **NOTE:** *Fertility preservation for medical indication does not make one eligible for IVF, which is specifically excluded from the medical benefits package under 38 C.F.R. § 17.38.*

(2) Evaluation and counseling are appropriate in considering whether the Veteran's medical condition or planned treatment will negatively affect fertility. This may include laboratory and ultrasound testing as well as counseling to consider whether the time needed for sperm collection or retrieval, oocyte stimulation and retrieval or ovarian tissue retrieval poses additional risks to the Veteran (e.g., delaying cancer chemotherapy to stimulate or collect gametes). The need to preserve gametes must be balanced against the needs to receive timely treatment (e.g., chemotherapy). There is a maximum of three gamete retrievals for fertility preservation for a medical indication; if there is a compelling indication for additional gamete retrievals (e.g., a person seeking gender-affirming care who has not reached the target number of 15-22 mature oocytes or 10-15 million motile sperm, provided that delays in care do not imminently threaten the health of the patient), this may be decided locally on a case-by-case basis.

(3) Delayed childbearing or age-related diminishing ovarian reserve are not considered medical indications for fertility preservation. **NOTE:** *Aside from Veterans, other beneficiaries are not eligible for VA-authorized fertility preservation for medical indication. CHAMPVA beneficiaries should refer to <https://www.va.gov/COMMUNITYCARE/programs/dependents/champva/champva-eligibility.asp>; CITI beneficiaries should refer to www.va.gov/COMMUNITYCARE/programs/dependents/champva/CITI.asp; CLFMP beneficiaries should refer to www.va.gov/COMMUNITYCARE/programs/dependents/CLFMP.asp.*

(4) For Veterans who have previously cryopreserved autologous gametes or embryos for a medical indication for a condition which potentially would have altered the functioning of gonads (testes, ovaries) (e.g., chemotherapy or gender-affirming medical interventions) prior to enrollment date, VA provides cryopreservation as it does for Veterans whose gametes have been retrieved through VA benefits.

(5) Storage of cryopreserved gametes/ovarian tissue/previously created embryos (henceforth referred to as specimens) takes place at an independent community care facility, and storage costs are covered yearly for up to 10 years. If there is a compelling indication for ongoing storage beyond 10 years, this may be decided locally on a case-by-case basis, up to 10 additional years of storage. Guidance for proper handling, labeling and storage of cryopreserved specimens is provided through VA-authorized referrals for Veterans for whom it is medically indicated (e.g., chemotherapy, gender-

affirming medical interventions). The storage agreement and permissions are between the Veteran and the independent storage facility (vendor). VA does not have ownership or custody of cryopreserved specimens and is not involved in the ultimate disposition of excess specimens. The Veteran must be informed of their respective financial responsibility for the storage after the 10 years are complete. Maximum time limits for storage and other limitations on specimen use are dictated by the storage facility and the community care facility that performs treatment using these specimens in the future. After initial transport to the storage facility, the Veteran is responsible for arranging and paying for transportation of these cryopreserved specimens should the Veteran decide to use them in the future. Contingencies for length of storage and disposition of specimens in the case of an unexpected life event (such as divorce or death of the Veteran) must be delineated at the initiation of storage, in an authorization agreement between the Veteran and the storage facility. **NOTE:** *The 10-year storage limit is effective as of the publication date of this directive. This benefit is not retroactive, and VHA will not reimburse any out-of-pocket expenses for storage of cryopreserved specimens paid prior to publication of this directive. For those who previously had authorization for 5 years, they are now eligible for up to 10 years, with an additional 10 years on a case-by-case basis, as determined locally. The 10-year limit is calculated based on storage paid by VHA, whether consecutive or non-consecutive. Storage through self-pay or by a third party does not count towards the 10-year limit.*

(6) VA will stop payment for fertility preservation for a medical indication in the following circumstances:

(a) Ownership of the cryopreserved specimens is transferred to a third party (e.g., a sibling of the Veteran who did not originate the gametes).

(b) The time limit for payment of storage is exceeded.

(c) Fertility preservation for a medical indication is not in accordance with generally accepted standards of medical practice.

(d) The specimens are cryopreserved at or transferred to an independent storage facility that is not registered with the Food and Drug Administration.

(e) VA determines that fertility preservation is not needed to preserve, promote or restore health of the Veteran.

(f) Upon death of the Veteran.

(7) VA health care providers must consult with OWH and IVC when the medical standards for fertility preservation for medical indication of specimens are unavailable or unclear. VA health care providers may also consult with SCI/D, NCEHC or NSO as needed. When the medical standards are unavailable or unclear, an expert panel may be required. Such a panel could be comprised of VA medical facility staff, including members of the Health Care Ethics Consultation Service, VA health care providers and other fertility evaluation and treatment experts. The final determination of eligibility is

made by the VA medical facility after consultation with the VA medical facility-led Fertility IDT (or VISN-led Fertility IDT, if none exists at the VA medical facility).

d. **Fertility Medications.** Fertility medications and regimens are complex and managed by health care providers with specialty training and expertise (e.g., reproductive endocrinology and infertility specialists). Most fertility treatment occurs outside VA, under authorized care in the community. The health care provider managing the fertility care must prescribe needed fertility medications; either by providing a written prescription to the Veteran, faxing a prescription to the local VA pharmacy, or prescribing electronically (e.g., through eScrip for the VA pharmacy). Commonly used fertility medications are listed on the VA National Formulary and can be ordered but often are not stocked in VA pharmacies. Communication and coordination of care is essential to minimize delays in care and avoid cancelled cycles. A local VA pharmacy process must be developed to procure and dispense fertility medications; this includes provision of evidence-supported compounded fertility medications from state licensed or Food and Drug Administration (FDA) compounding pharmacies/facilities, if the VA pharmacy cannot prepare in-house.

e. **Benefit Exclusions.** The following procedures or services are not included in the medical benefits package:

(1) Gestational surrogacy.

(2) Costs of obtaining, transporting and storing donor specimens.

(3) Transportation of VA-authorized cryopreserved autologous gametes/ovarian tissue/embryos after initial transport paid by VA from the collection facility to the storage facility.

(4) IVF procedures. **NOTE:** *For certain Veterans, IVF may be covered at 38 C.F.R. § 17.380. The beneficiary spouse of a Veteran in this instance would be authorized to receive IVF as well as fertility counseling and treatment that is available under the medical benefits package (38 C.F.R. § 17.412).*

(5) Fertility, evaluation and management of partners who are not eligible for VA health care. **NOTE:** *The beneficiary spouse of a Veteran authorized for care under 38 C.F.R. § 17.380 may be provided with fertility evaluation, counseling and treatment that is available under the medical benefits package, as well as IVF (38 C.F.R. § 17.412).*

4. TRAINING

The following training is recommended for relevant VA health care providers and staff, excluding health professions trainees, who may interact with a beneficiary with regards to fertility management:

a. Women's Health Inter-Professional: Infertility Recording, Talent Management System (TMS) VA 42504;

- b. Male Fertility Evaluation and Procedures within the VA System, TMS VA 131004320;
- c. LGB: Fertility and Family Building, TMS VA 44892;
- d. Serving Those Who Served: Infertility Care for Veterans, TMS VA 131004654;
- e. Female and Male Infertility: Incidence, Causes, and Care in the VA, TMS VA 34195;
- f. Gynecology Grand Rounds: Infertility Evaluation and Treatment for the Generalist Gynecologist, TMS VA 131008903;
- g. Fertility Community of Practice monthly call (email VHACOReproductiveHealthTeam@va.gov for updated information).

5. RECORDS MANAGEMENT

All records, regardless of format (e.g., paper, electronic, electronic systems), created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

6. BACKGROUND

a. VA is committed to promoting, preserving and restoring the health and well-being of all beneficiaries. For many individuals, having children is an important and essential aspect of life. Those who desire but are unable to conceive children themselves may experience feelings of depression, grief and inadequacy; poor adjustment; and reduced quality of life. Some Veterans may undergo medically necessary treatment that is expected to negatively impact their future fertility. They may benefit from fertility preservation services such as retrieval and cryopreservation of their gametes (eggs or sperm). Individuals with uteri who have had repeated miscarriages may also benefit from an evaluation to address their recurrent pregnancy loss. Age is significantly correlated to fertility, and thus those with ovaries or uteri who are 35 years old and older must receive expedited evaluation if they fail to conceive after 6 months. If there is a clear cause of decreased probability of conception per menstrual cycle (e.g., SCI/D and inability to ejaculate, a person with testes born without vas deferens, absence of procreative sex by a single person or a person partnered with someone with same-sex gametes), evaluation and fertility treatment may be offered immediately or after a shortened period of attempting unassisted conception. Other individuals may be certain that they do not desire (additional) children now or in the future and therefore seek permanent sterilization procedures. Fertility management contributes to the promotion, preservation and restoration of the health and well-being of beneficiaries as the ability to control one's fertility is essential to overall quality of life and health outcomes.

b. In recent years, the number of requests from beneficiaries for fertility management services has increased dramatically. There are several underlying reasons for this growing demand. Veterans with ovaries or uteri from Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn are enrolling in VA health care in record numbers. Many incoming Veterans are capable of a pregnancy. In the U.S., about 12% of individuals with ovaries and uteri have difficulty becoming pregnant or carrying a pregnancy to term (see [cdc.gov/nchs/nsfg/key_statistics/i.htm](https://www.cdc.gov/nchs/nsfg/key_statistics/i.htm)).

c. The demand for fertility management services is also increasing among lesbian, gay, bisexual, transgender, queer and related identities (LGBTQ+) Veterans, especially couples with same-sex gametes and transgender, gender diverse and intersex Veterans who are pursuing gender-affirming medical interventions, including surgery. Approximately two-thirds of LGBTQ+ adults are of reproductive age, and LGBTQ+ people are overrepresented among both the military and Veteran populations. Over 100,000 service members received other than honorable discharges based on sexual orientation or gender identity or a combination thereof, including 14,000 under Don't Ask, Don't Tell through 2011. In 2021, VA issued guidance to reinstate VA benefits for those LGBTQ+ Veterans.

d. History of military service may negatively affect individuals' ability to build their families without fertility treatment. Moreover, genital injuries in combat are not uncommon, and with the advent of improvised explosive devices, there is an increase in the risk of genital damage in military personnel who have survived these attacks.

e. Some medically necessary treatment is known to have a potentially deleterious effect on future fertility. This treatment includes, but is not limited to, cytotoxic chemotherapy and gender-affirming medical interventions. It is consistent with VA's commitment to promoting, preserving and restoring the health and well-being of all Veterans to offer fertility preservation to these Veterans.

f. Finally, some individuals are certain that they do not want to have (additional) biological children. These individuals may choose permanent elective sterilization (e.g., salpingectomy, tubal occlusion procedures, vasectomy). It is important that individuals choosing permanent sterilization are provided with detailed information about the risks, benefits and alternatives to permanent sterilization as these methods of sterilization are meant to be irreversible.

7. DEFINITIONS

a. **Assisted Reproductive Technology**. Assisted reproductive technology (ART) is all treatments or procedures that include the in vitro handling of oocytes or embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, IVF, embryo transfer, intracytoplasmic sperm injection (ICSI, pronounced "ick'-see"), oocyte/ovarian tissue/embryo cryopreservation, oocyte and embryo donation and gestational surrogacy. ART does not include the in vitro handling of sperm alone or IUI. ***NOTE: IVF is specifically excluded from the medical benefits package under 38 C.F.R. § 17.38; however, for fertility counseling and treatment under VA's special legislative***

authority, VA may provide ART, including IVF, for certain Veterans under 38 C.F.R. § 17.380. The spouse of such a Veteran may be provided with fertility counseling and treatment, including IUI and ART, under 38 C.F.R. § 17.412. Provisions of fertility counseling and treatment under VA's special legislative authority are further delineated in VHA Directive 1334(1).

b. **Beneficiary.** A beneficiary is a person determined eligible for provisions of benefits furnished by VA in the form of cost sharing (e.g., through CHAMPVA), health care (e.g., eligible Veterans or CHAMPVA beneficiaries through the CITI) or reimbursement (e.g., through the CLFMP).

c. **Cryopreservation.** Cryopreservation is the freezing or vitrification of gametes (oocytes or sperm), zygotes (1-cell fertilized oocytes), embryos (stage after zygote cleavage, typically cryopreserved on day 2, 3, 5 or 6 of development) or ovarian tissue, to allow storage for future use. Further development and aging remain arrested during the storage of these cryopreserved tissues.

d. **Embryo.** An embryo is the collection of cells that has developed from an oocyte fertilized by sperm.

e. **Female.** A female is a person with ovaries or a uterus. **NOTE:** *This directive discusses reproductive organs, rather than karyotype, although different variables may be used to define female sex based on context as sex is not binary.*

f. **Fertility Counseling.** Fertility counseling, also referred to as procreative management, is the initial assessment and ongoing counseling for fertility evaluation for an individual or couple who is looking to conceive.

g. **Gamete.** A gamete is mature sperm or oocyte.

h. **Genetic Testing.** Genetic testing is the assessment of genetic material. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine the likelihood of developing or passing on a genetic disorder.

i. **Gestational Surrogacy.** Gestational surrogacy is a process whereby one person carries a fetus through pregnancy and gives birth to a baby for another person or couple. The person who carries the fetus is called a gestational carrier or surrogate. The person or couple who are seeking to parent the baby or babies are called the intended parents.

j. **Gonadal Tissue.** Gonadal tissue is a reproductive organ (i.e., testes or ovaries) that contains cells that are responsible for producing gametes (oocytes or sperm) and hormones. **NOTE:** *Cryopreservation of testicular tissue among post-pubescent patients is experimental at this time; therefore, it is not a covered benefit.*

k. **Hysterosalpingogram.** A hysterosalpingogram (HSG) is a radiological procedure to investigate the shape of the uterine cavity and the shape and patency of the fallopian tubes (i.e., assessing whether the tubes are blocked).

l. **Infertility.** Infertility is a disease, condition, or status characterized by any of the following:

(1) The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

(2) The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.

m. **Intersex.** Intersex is an umbrella term for a wide spectrum of natural variations in sex characteristics involving chromosomal, hormonal, endocrinological, and anatomical configurations that do not fit the standard definitions of female and male. Intersex can also be used as an identity term for someone with one of these conditions.

n. **Intrauterine Insemination.** IUI is a procedure in which a small catheter (tube) is inserted through the cervix (the natural opening of the uterus) into the uterus to deposit a washed and concentrated sperm sample. It is also known as artificial insemination. IUI is not an ART procedure.

o. **In Vitro Fertilization.** IVF is an ART procedure in which an oocyte is removed from a mature ovarian follicle or thawed from cryopreservation and fertilized by a sperm cell outside the body. The fertilized oocyte is allowed to divide in a protected environment for several days, becoming an embryo. The newly formed embryo is transferred into the uterus or may be cryopreserved. ***NOTE: IVF is specifically excluded from the medical benefits package under 38 C.F.R. § 17.38, however, for fertility counseling and treatment under VA's special legislative authority, VA may provide ART, including IVF, for certain Veterans under 38 C.F.R. § 17.380. The spouse thereof may be provided with fertility counseling and treatment, including IUI and ART, under 38 C.F.R. § 17.412. Provisions of fertility counseling and treatment under VA's special legislative authority are further delineated in VHA Directive 1334(1).***

p. **Male.** A male is a person with testes. ***NOTE: This directive discusses reproductive organs, rather than karyotype, although different variables may be used to define male sex based on context as sex is not binary.***

q. **Oncofertility.** Oncofertility is an interdisciplinary field at the intersection of oncology and reproductive medicine that expands fertility options for patients who have been, or are being, treated for cancer.

r. **Oocyte.** An oocyte is a gamete produced by the ovary; it is also called an egg.

s. **Pregnancy Options Counseling.** Pregnancy options counseling is non-directive, neutral, unbiased discussion to aid a pregnant person in making fully informed decisions regarding options to continue a pregnancy or have an abortion.

t. **Preimplantation Genetic Testing.** Preimplantation genetic testing (PGT) is the testing of preimplantation stage embryos for genetic defects. PGT comprises a group of genetic assays used to evaluate embryos before transfer to the uterus. Embryos created through ART may be evaluated using PGT, including PGT for aneuploidy (PGT-A, formerly preimplantation genetic screening (PGS)), PGT for monogenetic/single-gene diseases (PGT-M, formerly preimplantation genetic diagnosis (PGD)) and PGT for structural rearrangements (PGT-SR) before being transferred into a uterus. PGT is not an ART procedure itself, but it is only available as part of ART.

(1) **Preimplantation Genetic Testing for Aneuploidy.** PGT-A (formerly PGS) is a set of techniques for testing whether embryos obtained through IVF/ICSI have an abnormal number of chromosomes (e.g., Down syndrome, trisomy 13).

(2) **Preimplantation Genetic Testing for Monogenetic/Single-Gene Diseases.** PGT-M (formerly PGD) is when one or both genetic prospective parents has a known genetic abnormality and testing is performed on an embryo to determine if it also carries a genetic abnormality (e.g., sickle cell, Tay-Sachs disease, cystic fibrosis).

(3) **Preimplantation Genetic Testing for Structural Rearrangements.** PGT-SR is testing to detect structural chromosomal abnormalities such as translocations, inversions, deletions, or insertions, often in conjunction with chorionic villus sampling or amniocentesis.

u. **Semen Analysis.** Semen analysis is the study of fresh or thawed semen under the microscope to count the number of sperm in millions per milliliter (concentration), to check the shape and size of the sperm (morphology), and to note their ability to move (motility), among other indices.

v. **Sperm Retrieval Techniques.** Sperm retrieval techniques are methods used to retrieve sperm when a person with testes is unable to ejaculate sperm (frequently a result of a SCI/D or side effect of medications). Techniques include electroejaculation, vibratory stimulation or surgical sperm retrieval (e.g., microsurgical epididymal sperm aspiration, percutaneous epididymal sperm aspiration, testicular sperm extraction and percutaneous testicular sperm aspiration).

8. REFERENCES

- a. P.L. 116-260 Division J, Title II § 234.
- b. 38 U.S.C. §§ 1101(21) 710, 1781(b), 1787, 7301(b).
- c. 38 C.F.R. §§ 17.270-17.279, 17.272(a)(64), 17.37, 17.38, 17.270-17.279, 17.380, 17.412.
- d. VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.

e. VHA Directive 1108.07(1), General Pharmacy Service Requirements, dated November 28, 2022.

f. VHA Directive 1108.08, VHA Formulary Management Process, dated July 29, 2022.

g. VHA Directive 1110.04(1), Integrated Case Management Standards Of Practice, dated September 6, 2019.

h. VHA Directive 1330.02, Women Veterans Program Manager (WVMP), August 10, 2018.

i. VHA Directive 1330.03, Maternity Health Care and Coordination, dated November 3, 2020.

j. VHA Directive 1334(1), In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses, dated March 12, 2021.

k. VHA Directive 1341(3), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

l. CHAMPVA.

www.va.gov/COMMUNITYCARE/programs/dependents/champva/index.asp.

m. CHAMPVA Eligibility.

<https://www.va.gov/COMMUNITYCARE/programs/dependents/champva/champva-eligibility.asp>.

n. CHAMPVA In-House Treatment Initiative (CITI).

<https://www.va.gov/COMMUNITYCARE/programs/dependents/champva/CITI.asp>.

o. VHA Health Information Management. Records Management.

<https://dvagov.sharepoint.com/sites/vhahealth-information-management/SitePages/Records-Management.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

p. VHA Office of Women's Health, Reproductive Health, Abortion.

<https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Abortion.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

q. VHA Office of Women's Health, Reproductive Health, Fertility.

<https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Fertility.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

r. Centers for Disease Control and Prevention. National Center for Health Statistics. National Survey of Family Growth. Key Statistics from the National Survey of Family Growth - I Listing. cdc.gov/nchs/nsfg/key_statistics/i.htm.

COMPARISON OF VHA DIRECTIVES 1332 AND 1334 BY ELIGIBILITY GROUP

This table is a comparison of Veterans; Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), including CHAMPVA In-House Treatment Initiative (CITI), Beneficiaries; and Certain Eligible Veterans and Their Spouses. All fertility management policy covering Veterans and CHAMPVA/CITI beneficiaries is under the purview of VHA Directive 1332, Fertility Management, dated May 13, 2024. The one exception is fertility counseling and treatment for certain eligible Veterans and their spouses, which is covered under VHA Directive 1334(1), In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses, dated March 12, 2021.

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Eligibility	Enrolled Veterans, or as otherwise authorized by 38 C.F.R. § 17.37	The spouse, widower, or children of a Veterans as authorized by 38 C.F.R. § 17.271	<ul style="list-style-type: none"> • 38 C.F.R. § 17.380: Certain eligible Veterans with a service-connected condition, or treatment thereof, resulting in the inability to procreate without the use of fertility treatment • 38 C.F.R. § 17.412: The legal spouse thereof

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Service connection	Not considered or required. If a Veteran has a service-connected condition with a potentially causal link to a diagnosis of infertility, eligibility is determined for provisions of fertility counseling and treatment through the Department of Veterans Affairs' (VA's) special legislative authority under VHA Directive 1334(1). If a Veteran eligible for VA's special legislative authority gets a consult and authorization under VHA Directive 1332, the Veteran may need to pay for out-of-pocket costs (e.g., for intrauterine insemination (IUI) for a spouse) that should be covered by VA.	Not applicable	Requires that a service-connected condition, or treatment thereof, that results in the inability of the Veteran to procreate without the use of fertility treatment. For a Veteran with sperm, a service-connected condition, or treatment thereof, that prevents the successful delivery of sperm to an oocyte; and, for a Veteran with oocytes and a patent uterine cavity, a service-connected condition, or treatment thereof, that prevents the oocyte from being successfully fertilized by a sperm; determined at the VA medical facility level.
Marital status	Not considered, no partner required	Not considered, no partner required	VA can only authorize treatment for qualifying Veterans and their lawful spouses, as defined in Federal statute and regulation. However, marriage is not a prerequisite for this benefit. Single Veterans pay out-of-pocket for acquisition of donor specimens and any care for non-authorized partners.

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Fertility counseling (separate from genetic counseling, see below) – includes psychological counseling and screening necessary to support the patient’s treatment plan	Yes	Yes	Yes
Behavioral counseling related to fertility	Yes	Yes	Yes, for Veteran, spouse, or, if both partners have VA authorization for care, the couple together.
Laboratory blood testing	Yes	Yes	Yes
Surgical correction of structural pathology consistent with standard of care	Yes	Yes	Yes
Permanent sterilization: <ul style="list-style-type: none"> • Salpingectomy • Tubal occlusion procedures • Vasectomy 	Yes	Yes	No
Sterilization reversal	Yes	No	Yes

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Diagnostics and treatment (common exemplars)	<ul style="list-style-type: none"> • Pelvic or transvaginal ultrasound • Hysterosalpingogram (HSG) • Saline-infused sonohysterogram • Reversal of tubal ligation • Transrectal or scrotal ultrasonography • Evaluation and treatment of erectile dysfunction • Vasectomy reversal (i.e., vasovasostomy) • Semen analysis • Post-ejaculatory urinalysis 	<ul style="list-style-type: none"> • Pelvic or transvaginal ultrasound • HSG • Saline-infused sonohysterogram • Transrectal or scrotal ultrasonography • Evaluation and treatment of erectile dysfunction • Semen analysis • Post-ejaculatory urinalysis 	<ul style="list-style-type: none"> • Pelvic or transvaginal ultrasound • HSG • Saline-infused sonohysterogram • Reversal of tubal ligation • Transrectal or scrotal ultrasonography • Evaluation and treatment of erectile dysfunction • Sperm retrieval techniques • Vasectomy reversal (i.e., vasovasostomy) • Semen analysis • Post-ejaculatory urinalysis

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
<p>IUI: six ovulatory cycles of IUI per pregnancy</p>	<p>The Veterans Health Administration (VHA) can only pay for procedures for eligible Veterans.</p> <ul style="list-style-type: none"> • For Veterans with ovaries and uteri, VHA will pay for the IUI procedures. The use of donated sperm is allowed if the Veterans pays for the acquisition and processing of the donated sperm. • For Veterans with sperm, VHA will pay for the sperm washing and processing but not the IUI procedure when sperm is inseminated into the uterus of a non-Veteran. • If both partners are Veterans, each Veteran will need their own consult and authorization for VHA to pay for all parts of IUI. 	<p>No</p>	<p>For both the Veteran and legal spouse: sperm retrieval, processing, washing, and the insemination procedure are all covered benefits. Veterans pay out-of-pocket for acquisition of donor specimens and any care for a non-authorized partner.</p>

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Retrieval of oocytes and ovarian tissue	Only for fertility preservation for medical indication for gonadotoxic treatments (e.g., chemotherapy, radiation, and surgery) that will adversely impact fertility (for Veterans with cancer, hematologic conditions, or who are transgender, gender-diverse or intersex undergoing gender-affirming medical interventions). The need to preserve gametes must be balanced against the needs to receive timely treatment (e.g., chemotherapy). There is a maximum of three gamete retrievals for fertility preservation for medical indication; if there is a compelling indication for additional gamete retrievals (e.g., a person seeking gender-affirming care who has not reached the target number of 15-22 mature oocytes, provided that delays in care do not imminently threaten the health of the patient), this may be decided locally on a case-by-case basis.	No	Yes
Sperm retrievals	No	No	Yes

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Use of donor oocytes and embryos	No, the use of or need for donor oocytes and embryos, by itself, does not render a Veteran ineligible for fertility services covered by VHA; however, donor oocytes and embryos are only used in the setting of assisted reproductive technology (ART)/in vitro fertilization (IVF), which are not covered services under the medical benefits package.	No	Veterans pay out-of-pocket for acquisition of donor specimens and any care for a non-authorized partner.

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Cryopreservation and storage of gametes/ovarian tissue	For Veterans with a medical indication for fertility preservation for gonadotoxic treatment only. There is a maximum of three gamete retrievals for fertility preservation for a medical indication; if there is a compelling indication for additional gamete retrievals (e.g., a person seeking gender-affirming care who has not reached the target number of 15-22 mature oocytes or 10-15 million motile sperm, provided that delays in care do not imminently threaten the health of the patient), this may be decided locally on a case-by-case basis. Storage is for up to 10 years. If there is a compelling indication for ongoing storage beyond 10 years, this will be decided at the VA medical facility level on a case-by-case basis, up to 10 additional years of storage.	No	For Veterans and spouse, only for autologous gametes (i.e., their own eggs and sperm), without time limits.

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Cryopreservation and storage of embryos	For Veterans who have previously cryopreserved autologous embryos for a medical indication for gonadotoxic therapies (e.g., chemotherapy, radiation, or gender-affirming medical interventions) prior to enrollment date, VA provides storage for up to 10 years as it does for Veterans whose gametes/ovarian tissue have been retrieved through VA benefits. If there is a compelling indication for ongoing storage beyond 10 years, this will be decided at the VA medical facility level on a case-by-case basis, up to 10 additional years of storage.	No	Cryopreservation and storage without time limits, unless the embryos are transferred to a third party for use or purposes outside the VA's special legislative authority
Transportation of gametes/gonadal tissue/embryos paid by VA	Not after initial transport	No	Not after initial transport
IVF	Not paid by VA	No	Yes
Surrogacy	No	No	No
Genetic counseling	For Veteran only	Yes, for beneficiary only	Yes, for Veteran and spouse

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Genetic testing, including serum (e.g., blood sample for sickle cell trait or cystic fibrosis disease or trait) and tissue (biopsy of malignant tissue or buccal smear, or tissue swab from inside the cheek); chromosome analysis in cases of habitual abortion or infertility	Yes, for Veterans only	Yes. However, routine or demand genetic testing, or genetic tests performed to establish the paternity or sex of a fetus, are excluded from coverage.	Yes
Pregnancy options counseling (including abortion counseling if indicated)	Yes	Yes	Yes
Abortion	VA offers abortions to Veterans eligible for care under the medical benefits package (38 C.F.R. § 17.38(c)(1) if determined needed by a health care professional when: (1) the life or health (including mental health) of the pregnant Veteran would be endangered if the pregnancy were continued; or (2) the pregnancy is the result of an act of rape or incest.	VA offers abortions, including selective reductions, to CHAMPVA beneficiaries eligible for care under 38 C.F.R. § 17.272(a)(64) when: (1) the life or health of the pregnant patient would be endangered if the pregnancy were carried to term; or (2) if the pregnancy is the result of an act of rape or incest.	Not under this authority, although Veterans and CHAMPVA beneficiaries requiring abortion or selective reduction could be eligible for an abortion under the medical benefits package (38 C.F.R. § 17.38(c)(1)) if determined needed by a health care professional when the life or health of the pregnant Veteran would be endangered if the pregnancy were carried to term.

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Preimplantation genetic testing (PGT)	No, this is a type of ART only used on embryos for IVF	No	Yes
PGT for aneuploidy (PGT-A, formerly preimplantation genetic screening)	No, this is a type of ART only used on embryos for IVF (used to test for normal chromosome number to identify conditions such as trisomy 13 or trisomy 21 (Down Syndrome))	No	Yes
PGT for monogenetic/single-gene diseases (PGT-M, formerly preimplantation genetic diagnosis)	No, this is a type of ART only used on embryos for IVF (used to test for specific known genetic disorders, e.g., sickle cell, Tay-Sachs disease or cystic fibrosis)	No	Yes
PGT for structural rearrangements (PGT-SR)	No, this is a type of ART only used on embryos for IVF (used to test for chromosomal gains and losses related to parental structural chromosomal abnormalities)	No	Yes

Group	Veterans (Covered in VHA Directive 1332)	CHAMPVA/CITI Beneficiaries (Covered in VHA Directive 1332)	Certain Eligible Veterans and Their Spouses (Covered in VHA Directive 1334)
Hormonal therapies	<p>For timed intercourse and IUI:</p> <ul style="list-style-type: none"> • Oral medications (e.g., clomiphene citrate). Maximum of six ovulatory cycles per pregnancy. • Injectable gonadotropin medications (e.g., follicle-stimulating hormone, luteinizing hormone, combination human menopausal gonadotropins). Maximum of six ovulatory cycles per pregnancy. • Additional hormonal therapies that are indicated to support ovulation induction treatment cycles (e.g., progesterone for luteal phase support, human chorionic gonadotropin to trigger ovulation). <p>For fertility preservation for medical indication.</p>	<p>Yes, hormone therapy for coital interventions (e.g., timed intercourse) only</p> <ul style="list-style-type: none"> • Oral medications (e.g., clomiphene citrate). Maximum of six ovulatory cycles per pregnancy. • Injectable gonadotropin medications (e.g., follicle-stimulating hormone, luteinizing hormone, combination human menopausal gonadotropins). Maximum of six ovulatory cycles per pregnancy. • Additional hormonal therapies that are indicated to support ovulation induction treatment cycles (e.g., progesterone for luteal phase support, human chorionic 	Yes

FERTILITY PRESERVATION FOR MEDICAL INDICATION

Indication for Fertility Preservation	Covered by VHA
Veterans with cancer: oncofertility with cryopreservation of gametes to preserve fertility prior to cancer treatment which would ordinarily significantly impact the Veteran’s future fertility	Yes
Veterans with a medical condition (e.g., sickle cell disease or some hematologic conditions, especially if bone marrow transplant is required) requiring gonadotoxic treatments	Yes
Surgeries or procedures that may potentially result in loss of a gonad	Yes
Transgender and gender-diverse Veterans: gender-affirming medical interventions that affects fertility	Yes
Delayed childbearing	No
Age-related diminishing ovarian reserve	No
Elective sterilization	No
Failed reversal of sterilization	No
Prior to hysterectomy or vasectomy	No
Surgeries or procedures that may disrupt gamete transport	No

NOTE: This is a list of common indications and requests for fertility preservation; this is not all-inclusive.