

METHODS OF TREATING INFERTILITY

FIELD OF INVENTION

The invention described herein relates to assisted reproductive technology. In particular, described herein are methods for treating infertility, including controlled ovarian stimulation methods that may be particularly useful for women at risk of a high ovarian response thereto.

BACKGROUND OF THE INVENTION

Assisted reproductive technology (ART) procedures generally involve stimulating egg production, harvesting eggs from a woman's ovaries, combining them with sperm *in vitro*, and transferring them to a woman's uterus (the donor or another woman). Success of ART is hampered by maternal and perinatal risks associated with the stimulation of egg production, such as ovarian hyperstimulation syndrome (OHSS) and ectopic pregnancy. Other concerns that arise in ART are the production of quality embryos and euploid blastocysts to support ongoing pregnancy rates and live birth rates.

Gonadotropins, such as menotropin (e.g., human menopausal gonadotropin, or hMG), follicle-stimulating hormone (FSH) and luteinizing hormone (LH), have been widely used for controlled ovarian stimulation (COS), and highly purified menotropin (HP-hMG) and recombinant human FSH (r-hFSH) have been used more recently. The efficacy of ovarian stimulation protocols may be enhanced using long gonadotropin hormone releasing hormone (GnRH) agonists or GnRH antagonists for cycle control. *See, e.g., Devroey et al. Fertility and Sterility* 97: 561-71 (2012).

Because patient responses to ovarian stimulation vary widely, treatments often are individualized. For example, individualization may be based on predicted ovarian response to gonadotropin stimulation, which forecasts poor, normal or high response. High ovarian responders usually are defined as women who produce high numbers of developing follicles following a standard protocol of controlled ovarian stimulation (COS). Although these patients are generally considered good candidates for ART, high ovarian response may be associated with lower implantation rates and higher miscarriage rates, and thus a decreased

chance of successful outcome as compared with a normal ovarian response. These high responders also are at greater risk for OHSS and the complications associated therewith.

It has been hypothesized that ovarian stimulation may have a general negative impact on embryo quality, as assessed by morphological parameters and/or chromosomal analysis (*e.g.*, euploidy vs. aneuploidy). *See, e.g.*, Hamdine *et al.*, “Ovarian Stimulation for IVF: Mild Approaches” in *Human Fertility: Methods and Protocols*, Methods in Molecular Biology, Vol. 1154, Springer Science+Business Media, New York (2014). Additionally, Haaf *et al.*, *Fertility and Sterility* 91(3): 733-38 (2009), reported that a high oocyte yield is associated with an increased chromosome error rate. However, Fatemi *et al.*, *Human Reproduction* 28(2) 442-52 (2013), reported that high ovarian response does not jeopardize ongoing pregnancy rates, but rather increases cumulative pregnancy rates.

Efforts to develop improved ART methods have involved exploring milder stimulation protocols. For example, Rubio *et al.*, *Human Reproduction* 25(9): 2290-2010 (2010), reported that decreasing the gonadotrophin dose administered to high responders could improve fertilization rates and embryo quality, although the lower doses resulted in a decreased number of oocytes. Other efforts have considered whether the specific gonadotropin used impacts the results. For example, Ziebe *et al.*, *Human Reproduction* 22(9) 2404-13 (2007), reported that the use of HP-hMG versus rFSH could impact the morphology of embryos, and observed improved implantation, ongoing pregnancy and live birth rates among the top-quality embryos derived from stimulation with HP-hMG compared with rFSH. It should be noted, however, that the Ziebe *et al.* findings were based on a visual assessment of oocyte/embryo on day three following retrieval, and not based on chromosomal analysis. As set out below, such a visual assessment at day three does not allow the detection of aneuploidy. Along the same lines, La Marca *et al.*, *Fertility and Sterility* O-169 (2012), reported that among predicted high responders (subjects having an AMH ≥ 5.2 ng/ml) the group stimulated with rFSH group had significantly more oocytes retrieved, but a significantly lower live birth rate per cycle as compared to the group stimulated with HP-hMG.

There remains a need, therefore, for improved assisted reproductive technology methods, particularly for women at risk of a high response to controlled ovarian stimulation.

SUMMARY OF THE INVENTION

According to the present invention there is provided a composition (e.g. a pharmaceutical composition) comprising menotropin (human menopausal gonadotropin or hMG) for use in the treatment of a patient (e.g. a woman at risk of high ovarian response to controlled ovarian stimulation) to thereby promote the development of euploid blastocysts for future blastocyst transfer, the treatment comprising:

identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) prior to treatment/stimulation [e.g. when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability)]; and

administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment. The dose may be, or be equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The treatment may

comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment to promote the development of euploid blastocysts for future blastocyst transfer may increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts. The treatment to promote the development of euploid blastocysts for future blastocyst transfer may reduce aneuploidy rate. Aneuploidy rate is discussed below.

The treatment may comprise administering a dose of, or a dose equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment to promote the development of euploid blastocysts for future blastocyst transfer may promote the development of euploid blastocysts (e.g. increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts) as compared to a comparable method using recombinant follicle-stimulating hormone (rFSH) as the gonadotropin.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

In an example, the treatment may comprise a step of administration to the patient a

dose of, or a dose equivalent to, 100 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to, 150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

According to the present invention in another aspect there is provided a composition comprising menotropin (human menopausal gonadotropin or hMG) for use in promoting the development of euploid blastocysts (for use in infertility treatment), the treatment comprising:

identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) prior to treatment/stimulation [e.g. when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability)]; and

administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment. The dose may be, or be equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less

than 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimüllerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The promotion of the development of euploid blastocysts (for use in infertility treatment) may increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts.

The treatment may comprise administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The promotion of the development of euploid blastocysts (for use in infertility treatment) may lead to an increase in proportion/percentage of euploid blastocysts as compared to a comparable method using recombinant follicle-stimulating hormone (rFSH) as the gonadotropin.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 75 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to,

150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

According to the present invention in a further aspect there is provided a composition comprising menotropin (human menopausal gonadotropin or hMG) for use in the treatment of infertility (e.g. controlled ovarian stimulation) to develop euploid blastocysts for future blastocyst transfer, the treatment comprising:

identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) prior to treatment/stimulation [e.g. when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability)]; and

administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment. The dose may be, or be equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm$

0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment to develop euploid blastocysts for future blastocyst transfer may increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts.

The treatment may comprise administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment to develop euploid blastocysts for future blastocyst transfer may increase the development of euploid blastocysts (e.g. increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts) as compared to a comparable method using recombinant follicle-stimulating hormone (rFSH) as the gonadotropin.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 75 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to,

150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

According to the present invention in a further aspect there is provided a composition comprising menotropin (human menopausal gonadotropin or hMG) for use in the treatment of infertility in a woman at risk of high ovarian response to controlled ovarian stimulation, the treatment comprising:

identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) [e.g. when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability)] and an antral follicle count (AFC) ≥ 10 in both ovaries combined prior to treatment/stimulation; and

administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment. The dose may be, or be equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment may comprise administering a dose of, or a dose equivalent to, 75 to

300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 75 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to, 150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment. The treatment may increase the number of metaphase II oocytes (e.g. resulting from the treatment) compared to equivalent treatment with FSH. The number of metaphase II oocytes will be assessed by methods well known in the art as discussed below.

According to the present invention in a further aspect there is provided a composition (e.g. a pharmaceutical composition) comprising menotropin (human menopausal gonadotropin or hMG) for use in the treatment of infertility to thereby promote the development of euploid blastocysts for future blastocyst transfer in a patient (e.g. a woman at risk of high ovarian response to controlled ovarian stimulation) identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) [e.g. when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability)] prior to treatment/stimulation and optionally identified as having an antral follicle count (AFC) ≥ 10 in both ovaries combined, prior to treatment/stimulation; the treatment comprising administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment. The dose may be, or be equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 10 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment to promote the development of euploid blastocysts for future blastocyst transfer may increase the proportion/percentage of euploid blastocysts compared to the

proportion/percentage of aneuploid blastocysts. The treatment to promote the development of euploid blastocysts for future blastocyst transfer may reduce aneuploidy rate. Aneuploidy rate is discussed below.

The treatment may comprise administering a dose of, or a dose equivalent to, 100 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment to promote the development of euploid blastocysts for future blastocyst transfer may promote the development of euploid blastocysts (e.g. increase the proportion/percentage of euploid blastocysts compared to the proportion/percentage of aneuploid blastocysts) as compared to a comparable method using recombinant follicle-stimulating hormone (rFSH) as the gonadotropin.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 100 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to, 150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

The foregoing general description and the detailed description are exemplary and explanatory and are intended to provide further explanation of the invention. For detailed understanding of the invention, reference is made to the following detailed description of specific embodiments, taken in conjunction with the accompanying figures. Other objects, advantages and novel features will be readily apparent to those skilled in the art from the following detailed description of the invention.

BRIEF DESCRIPTION OF THE DRAWINGS

Figure 1 shows (A) the occurrence of high ovarian response (≥ 15 oocytes retrieved) and (B) live birth rates (LBR) among women classified as potential high responders by a high initial anti-Müllerian hormone (AMH) level. Values within bars are n/total. p Values are based on the Chi-Square Test. The percentage of women with a high ovarian response is significantly lower for HP-hMG compared with rFSH in both the long agonist and the antagonist protocols.

Figure 2 sets forth a flow chart of the study design for the clinical trial of Example 2.

DETAILED DESCRIPTION

Described herein are assisted reproductive technology methods, e.g., methods for treating infertility. In particular, described herein are controlled ovarian stimulation (COS) methods that may be particularly useful for women at risk of a high ovarian response to controlled ovarian stimulation. In some embodiments, the methods are useful for optimizing ovarian response to COS, improving embryo quality, increasing the proportion of euploid blastocysts produced by *in vitro* fertilization after controlled ovarian stimulation, decreasing the proportion of aneuploid blastocysts produced by *in vitro* fertilization after controlled ovarian stimulation, decreasing aneuploidy rate e.g. after controlled ovarian stimulation, increasing ongoing pregnancy rates and/or increasing live birth rates.

The present invention is based on the unexpected finding by the inventors that the use of highly purified menotropin (HP-hMG) in potential high ovarian responders undergoing controlled ovarian stimulation (COS) may optimize ovarian response, improve embryo quality, increase the proportion of euploid blastocysts, decrease the proportion of aneuploid blastocysts, and improve ongoing pregnancy rates, and increases live birth rates.

Definitions

Technical and scientific terms used herein have the meanings commonly understood by one of ordinary skill in the art of assisted reproductive technology to which the present invention pertains, unless otherwise defined. Reference is made herein to various methodologies known to those of ordinary skill in the art. Any suitable materials and/or methods known to those of ordinary skill in the art can be utilized in carrying out the present invention. However, specific materials and methods are described. Materials, reagents and the like to which reference is made in the following description and examples are obtainable from commercial sources, unless otherwise noted.

As used herein, the singular forms “a,” “an,” and “the” designate both the singular and the plural, unless expressly stated to designate the singular only.

As used herein, the term “about” means that the number or range is not limited to the exact number or range set forth, but encompass ranges around the recited number or range as will be understood by persons of ordinary skill in the art depending on the context in which the number or range is used. Unless otherwise apparent from the context or convention in the art, “about” mean up to plus or minus 10% of the particular term.

As used herein, “optimizing ovarian response” refers to optimizing ovarian response to COS to achieve an optimal number of developing follicles, such as from 4-15 developing follicles, about 8-15 developing follicles, about 8-14 developing follicles, or about 11 developing follicles.

As used herein, “improving embryo quality” refers to increasing the proportion of euploid blastocysts (*e.g.*, blastocysts having the correct number of chromosomes) and/or decreasing the proportion of aneuploid blastocysts (*e.g.*, blastocysts having an incorrect number of chromosomes) produced in a single cycle of ART that involves COS followed by *in vitro* fertilization.

As used herein “ongoing pregnancy” refers to pregnancy with a viable fetus and detectable fetal heartbeat at 10-11 weeks gestation, *e.g.*, at 8-9 weeks post blastocyst/embryo transfer.

As used herein “clinical pregnancy” refers to gestation and a detectable fetal heartbeat at 5-6 weeks gestation, *e.g.*, at 3-4 weeks post blastocyst/embryo transfer.

As used herein, “woman” refers to an adult female human. In some embodiments, a woman treated in accordance with the methods described herein is identified as being 35 years old or younger, or is identified as being 34 years old or younger. In some embodiments, a woman treated in accordance with the methods described herein is identified as being 21-38 years old, or identified as being 21-37 years old, or identified as being 21-36 years old, or identified as being 21-34 years old, or identified as being 21-32 years old, or identified as being 21-31 years old (prior to treatment). In some embodiments, a woman treated in accordance with the methods described herein is identified (prior to treatment) as having a BMI of 38 kg/m² or less, 36 kg/m² or less, 34 kg/m² or less, 32 kg/m² or less, 30 kg/m² or less, or 28 kg/m² or less, such as BMI of 18-38, 18-36, 18-34, 18-32, 18-30, or 18-28 kg/m². In some embodiments, a woman treated in accordance with the methods described herein is identified as having a BMI of 18-25 kg/m², 18-26 kg/m², 18-29 kg/m², 18-30 kg/m², 18-32 kg/m², 18-34 kg/m², 18-36 kg/m² or 18-38 kg/m².

As used herein, subjects classified as being “at risk of a high ovarian response to controlled ovarian stimulation” refers to women who are likely to develop high numbers of follicles or oocytes following a standard protocol of controlled ovarian stimulation (COS), such as women with a greater than average likelihood of producing 15 or more oocytes. Women may be identified as being at risk if they have generated 15 or more oocytes in a previous ART

cycle, e.g., in a previous COS treatment. Additionally or alternatively, women may be identified as being at risk if they are considered to be at risk of developing OHSS.

Additionally or alternatively, women may be identified as being at risk if they have a serum level of anti-Müllerian hormone (AMH) of greater than or equal to about 5.0 ng/ml (such as greater than or equal to about 5.2 ng/ml) when assessed as described herein below (or an equivalent level when assessed by a different method). Additionally or alternatively, women may be identified as being at risk if they have an antral follicle count (AFC) of greater than or equal to 15, greater than or equal to 18, or greater than or equal to 20, in both ovaries combined, prior to stimulation.

The term “menotropin” as used herein includes human menopausal gonadotropin or hMG. The term “highly purified menotropin” as used herein includes HP-hMG available under the trademark MENOPUR® from Ferring B.V., that contains both follicle stimulating hormone (FSH) and human chorionic gonadotropin (hCG)-driven luteinizing hormone (LH)-activity.

The term “GnRH agonist” as used herein includes gonadotropin-releasing hormone (GnRH) agonists such as buserelin (e.g., Suprecur®), leuprorelin (e.g., Lupron®), nafarelin (e.g., Synarel®), and triptorelin (e.g., Trelstar®).

The term “GnRH antagonist” as used herein includes gonadotropin-releasing hormone (GnRH) antagonists, such as ganirelix acetate (e.g., Orgalutran®) and cetrorelix acetate (e.g., Cetrotide®), which block the action of GnRH by competitive blocking of the GnRH receptors on pituitary gonadotropes, and thus prevent gonadotropin production and eggs premature release.

As used herein, the phrase “effective amount” refers to the dosage that provides the specific pharmacological effect for which the drug is administered in a subject in need of such treatment. It is emphasized that a therapeutically effective amount will not always be effective in treating the conditions described herein, even though such dosage is deemed to be a therapeutically effective amount by those of skill in the art. For convenience only, exemplary dosages and therapeutically effective amounts are provided below with reference

to adult female human subjects. Those skilled in the art can adjust such amounts in accordance with standard practices as needed to treat a specific subject and/or condition/disease.

As noted above, the present invention provides reproductive technology methods that involve using highly purified menotropin (HP-hMG) in women at risk of a high ovarian response to COS and undergoing COS. As also noted above, for the purposes of the methods disclosed herein, women may be identified as being at risk of a high ovarian response to COS if they have a serum level of anti-Müllerian hormone (AMH) of greater than or equal to about 5.0 ng/ml, such as greater than or equal to 5.0 ± 0.5 ng/ml, such as greater than or equal to about 5.2 ± 0.5 ng/ml, when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability). Serum levels of AMH are a surrogate marker for functional ovarian follicle reserve, and a positive correlation between serum levels of AMH and ovarian response (e.g., oocyte yield) have been reported. *Id.* However, according to Arce *et al.*, AMH levels have not been correlated with embryo quality. *Id.*

Additionally or alternatively, as also noted above, for the purposes of the methods disclosed herein, women may be identified as being at risk of a high ovarian response to COS if they have an antral follicle count (AFC) of greater than or equal to 15, greater than or equal to 18, or greater than or equal to 20, in both ovaries combined, prior to stimulation. Antral follicles are small follicles (about 2-8 mm in diameter) that can be visualized and measured via transvaginal ultrasound. Antral follicles are another marker for ovarian reserve, and AFC has been used (along with other markers) to predict ovarian response to COS, e.g., to predict whether a given subject will be a low, normal, or high responder. However, AFC has not been correlated with embryo quality.

Assisted Reproductive Technology Methods

The methods described herein are useful in any reproductive technology methods that involve controlled ovarian stimulation (COS), such as for *in vitro* fertilization, including intra-

cytoplasmic sperm injection (ICSI), including methods involving fresh transfer of fertilized eggs (e.g., blastocysts/embryos) and methods that involving freezing fertilized eggs (e.g., blastocysts/embryos) for later implantation.

In specific embodiments, the subject undergoing COS is at risk of a high ovarian response to COS. In specific embodiments, the subject is identified by having a serum level of AMH of greater than or equal to about 5.0 ng/ml, such as greater than or equal to 5.0 ± 0.5 ng/ml, such as greater than or equal to about 5.2 ± 0.5 ng/ml ng/ml, when measured using a Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), or an equivalent AMH level assessed by a different method ($\pm$ its coefficient of variability).

In some embodiments, the subject is additionally or alternatively identified by having an AFC of greater than or equal to 15, greater than or equal to 18. or greater than or equal to 20, in both ovaries combined, prior to stimulation. In some embodiments, the subject is excluded from treatment by the methods described herein if the subject has an AFC of less than 8, or less than 10, in both ovaries combined, prior to stimulation. In some embodiments, subjects treated by the methods described herein have (are identified as having) an AFC of at least 10 (≥ 10) in both ovaries combined, prior to stimulation.

The subject may be additionally or alternatively identified as being at risk if they have generated 15 or more oocytes in a previous ART cycle, e.g., in a previous COS treatment, and/or if they are considered to be at risk of developing OHSS.

In specific embodiments, the methods include administering HP-hMG to the subject in an amount effective to stimulate follicle development. In some embodiments, HP-hMG is administered at a dose of from about 75 IU or 100 IU to about 300 IU/ day, or from about 75 to about 200 IU/day, or from about 100 to about 200 IU/day, for from about 1 to about 20 days, such as for at least 5 days. Pharmaceutical compositions comprising HP-hMG are available commercially, such as the MENOPUR® product sold by Ferring B.V., which is formulated for subcutaneous injection. Typically, a starting dose is 150 IU/day for the first 5 days, which may be adjusted thereafter (e.g., on day 6 onward) based on the subject's ovarian

(follicular) response, which may be assessed, for example, by transvaginal ultrasound (TVUS). For example, once the lead follicle reaches > 12 mm in diameter, the dose can be adjusted by 75 IU per adjustment. Typically, the dose is adjusted up or down when both the serum estradiol level and the number of follicles > 12 mm are either too low or too high on the 6th day of stimulation. HP-hMG is administered daily until the desired level of follicle production is reached. For example, HP-hMG may be administered until three follicles have developed with a diameter of > 17 mm, as may be determined by TVUS. Typically, the maximum HP-hMG dosing period is 20 days.

In some embodiments, the methods include the administration of a GnRH antagonist during a portion of the period of HP-hMG administration. For example, a GnRH antagonist may be administered once the lead follicle reaches 14 mm in diameter, and continued through the remainder of the period of HP-hMG administration. When the GnRH antagonist is ganirelix acetate (such as Orgalutran®), a typical dose is 0.25 mg/day administered subcutaneously.

In other embodiments, the methods include the administration of a GnRH agonist prior to ovarian stimulation, such as the administration of triptorelin (typically at 0.1 mg/day subcutaneously) or leuporelin (e.g., Lupron®).

Once the desired level of follicle production is reached, ovulation can be stimulated by methods known in the art, such as by a bolus injection of human chorionic gonadotropin (hCG). A typical dose of recombinant hCG (such as Ovitrelle®) is 250 µg (6,500 IU of hCG activity), usually administered by a single subcutaneous injection. Then, oocytes are retrieved and fertilized by methods known in the art, such as ICSI.

For fresh transfer methods, one or more blastocysts are selected for transfer a few days after fertilization (e.g. after 5 days). Remaining blastocysts can be frozen by methods known in the art for future transfer (including vitrification). In specific embodiments, the methods described herein are used in a single blastocyst transfer protocol, wherein a single blastocyst is selected for fresh transfer. In accordance with those embodiments, remaining blastocysts can be frozen by methods known in the art for future transfer.

For “freeze all” methods, selected blastocysts are frozen by methods known in the art for future transfer.

In specific embodiments, blastocyst selection is guided by morphological analysis. For example, morphological blastocyst quality can be assessed by determining blastocyst expansion and hatching status, inner cell mass grading and trophectoderm grading according to the Gardner blastocyst grading system. *See, e.g., Van den Abbeel et al., Reproductive Biomed. OnLine 27: 353-61 (2013).* For example, blastocysts with blastocyst expansion and hatching status 4, 5 or 6, inner cell mass grading A, and trophectoderm grading A or B may be deemed of “excellent” quality, while blastocysts with blastocyst expansion and hatching status 3, 4, 5 or 6, inner cell mass grading A or B, and trophectoderm grading A or B may be deemed of “good” quality.

Additionally or alternatively, blastocyst quality is assessed by chromosomal analysis, including genetic screening (e.g., preimplantation genetic screening, or PGS) to detect aneuploidy. In some embodiments, chromosomal analysis includes comprehensive chromosomal screening (CCS) as described, for example, in Forman *et al., Fertility and Sterility* 100: 718-24 (2013). As reported in this paper, CCS can be conducted prior to fresh transfer or prior to blastocyst freezing for future transfer.

According to the present invention in a further aspect there is provided a composition comprising menotropin for use in the treatment of infertility to reduce the aneuploidy rate in resulting blastocysts in a patient identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) [and, optionally, an antral follicle count (AFC) ≥ 10 in both ovaries combined, e.g. an antral follicle count (AFC) ≥ 15 in both ovaries combined prior to treatment/stimulation], the treatment comprising administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

Herein the term “aneuploidy rate” is defined as a percentage [e.g. for a subject (patient)] and calculated as 100 times the ratio of the number of aneuploid blastocysts to the total number of blastocysts. The number of aneuploid blastocysts may be determined e.g. by the methods

described above (e.g. chromosomal analysis such as PGS, CCS). The total number of blastocysts may be determined e.g. by methods well known in the art, (e.g. by those described and referred to in Example 2 below).

By “treatment of infertility to reduce the aneuploidy rate in resulting blastocysts” it is meant that the treatment reduces the aneuploidy rate in blastocysts which result from the treatment (e.g. effectively reduces the number of aneuploid blastocysts produced by the treatment relative to the total number of blastocysts produced by the treatment). The treatment may reduce the aneuploidy rate compared to equivalent treatment with FSH.

The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The patient may be identified as having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment may comprise administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally

intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 75 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to, 150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

According to the present invention in a further aspect there is provided a composition comprising menotropin for use in the treatment of infertility (in a patient) to reduce the aneuploidy rate in resulting blastocysts for future blastocyst transfer, the treatment comprising:

identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) [and, optionally, an antral follicle count (AFC) ≥ 10 in both ovaries combined, e.g. an antral follicle count (AFC) ≥ 15 in both ovaries combined prior to treatment/stimulation]; and

administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment.

The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 15 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 18 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) ≥ 20 in both ovaries combined, prior to treatment/stimulation.

The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 10 in both ovaries combined, prior to treatment/stimulation. The treatment may comprise identifying a patient having a serum antimullerian hormone (AMH) level $\geq 5.0 \pm 0.5$ ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) and an antral follicle count (AFC) not less than 8 in both ovaries combined, prior to treatment/stimulation.

The treatment may comprise administering a dose of, or a dose equivalent to, 75 to 300 IU hMG per day from day 1 to at least day 5 of treatment, for example from day 1 to day 10 of treatment, for example from day 1 to day 14 of treatment, for example from day 1 to day 20 of treatment.

The treatment may further comprise administering hCG (e.g. recombinant hCG) to trigger ovulation.

The treatment may further comprise: retrieving (e.g. harvesting) oocyte(s); fertilizing (e.g. inseminating) the oocytes (s); and allowing the fertilized oocytes to develop to the blastocyst stage. The fertilization (e.g. insemination) may be *in vitro* fertilization, optionally intra-cytoplasmic sperm injection (ICSI).

The treatment may further comprise assessing the chromosomal quality of blastocysts obtained after fertilization of the harvested oocytes (e.g. to identify one or more euploid blastocysts). The treatment may further comprise transfer of a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts (e.g. fresh transfer). The treatment may further comprise freezing a euploid blastocyst identified by assessment of chromosomal quality of the blastocysts.

The menotropin may be highly purified menotropin (HP-hMG).

The patient (subject) is preferably an ovulatory patient. In other words, it is preferred that the patient (subject) is not anovulatory.

In an example, the treatment may comprise a step of administration to the patient a dose of, or a dose equivalent to, 75 to 200 IU HP-hMG per day from day 1 to at least day 5 of treatment, for example a step of administration to the patient a dose of, or dose equivalent to, 150 IU HP-hMG per day from day 1 to at least day 5 of treatment. The treatment may comprise a further step of administering a GnRH antagonist on day 6 of treatment.

In some embodiments, luteal phase support is provided by the administration of progesterone, such as vaginal progesterone inserts, from the day after oocyte retrieval to 10-15 days after blastocyst/embryo transfer, and/or from the day of blastocyst/embryo transfer to the confirmation of ongoing pregnancy, in accordance with protocols known in the art.

In some embodiments, clinical pregnancy is confirmed by TVUS at 5-6 weeks gestation (e.g., 3-4 weeks after blastocyst/embryo transfer). In some embodiments, ongoing pregnancy is confirmed by TVUS at 10-11 weeks gestation (e.g., 8-9 weeks after blastocyst/embryo transfer).

In some embodiments, the subject is followed to assess pregnancy outcome (e.g. live birth) and/or neonatal health.

As set forth above, the methods described herein are useful for improving embryo quality, increasing the proportion of euploid blastocysts, decreasing the proportion of aneuploid blastocysts, increasing ongoing pregnancy rates and/or increasing live birth rates, as compared to comparable methods using recombinant follicle stimulating hormone (rFSH) as the gonadotropin. In particular, the methods described herein may result in an increased proportion of euploid blastocysts (e.g., a decreased proportion of aneuploidy blastocysts), as compared to comparable methods using rFSH as the gonadotropin. The methods described herein also may result in increased ongoing pregnancy rates and/or increased live birth rates, as compared to comparable methods using rFSH as the gonadotropin, such as an 8% or 10% or greater increase in ongoing pregnancy rates and/or increased live birth rates. In some embodiments, the methods result in fewer eggs but a higher proportion of euploid blastocysts as compared to comparable methods using rFSH as the gonadotropin.

Further aspects of the methods described herein are illustrated in the following examples, which are not limiting in any respect.

EXAMPLES

Example 1 – Retrospective Analysis

A retrospective analysis was undertaken of data collected in two randomized controlled clinical trials comparing treatment outcome in patients undergoing stimulation with HP-hMG or recombinant FSH following a long GnRH agonist protocol (Anckaert *et al.*, *Human Reproduction* 27: 1829-39 (2012)) or a GnRH antagonist protocol (Arce *et al.*, *Fertility and Sterility*, 99: 1644-53 (2013)).

1. Study populations

The main inclusion criteria for the long agonist trial were women aged 21–37 years with major indications for IVF (such as tubal factor infertility, unexplained infertility or mild male factor infertility), FSH levels within normal limits (1–12 IU/L), BMI of 18-29, and regular menstrual cycles of 21-35 days which were presumed to be ovulatory. The main inclusion criteria for the antagonist trial were women aged 21–34 years with a primary infertility diagnosis of unexplained infertility or mild male factor infertility, FSH levels of 1–12 IU/L, BMI of 18-25, and regular menstrual cycles of 24-35 days,

2. Study protocols

In the long agonist protocol, down-regulation was performed using triptorelin (0.1 mg/day) (Decapeptyl®, Ferring Pharmaceuticals A/S) initiated 5-7 days before the estimated start of next menses and continued until the end of gonadotropin administration. Gonadotropin (HP-hMG or rFSH) was administered at 225 IU/day for the first 5 days, and then adjusted according to ovarian response.

In the antagonist protocol, gonadotropin (HP-hMG or rFSH) was administered at 150 IU/day for the first 5 days, and then adjusted according to ovarian response from day 6. On day 6 GnRH antagonist (ganirelix, Orgalutran, MSD) was initiated at 0.25 mg/day and continued throughout gonadotropin-treatment.

In both protocols, 250 µg hCG (Choriogonadotropin alpha, Ovitrelle, Merck Serono) was administered when three follicles of ≥ 17 mm diameter were observed, and oocyte retrieval took place 36 ± 2 hours later.

Luteal support was provided by vaginal administration of progesterone

In the long agonist protocol, 1 or 2 embryos were transferred on day 3. In the antagonist protocol, 1 blastocyst was transferred on day 5.

Live birth was defined as delivery of (at least) one live-born neonate.

3. Serum assays

AMH was analyzed by enzyme-linked immunosorbent assay (long agonist trial: Immunotech Beckman Coulter AMH ELISA; antagonist trial: Beckman Coulter Gen 2 ELISA; 1 ng/ml = 7.14 pmol/L). The AMH assays had a sensitivity of 0.35 and 0.08 ng/ml and total imprecision (% coefficient of variation) of < 9.5 and < 7.7 in Immunotech Beckman Coulter and Beckman Coulter Gen 2, respectively. FSH, estradiol and progesterone were analyzed by electrochemiluminescence immunoassay (Roche-Diagnostics ECLIA).

4. Statistical analysis

In total, the two trials comprised 1372 women. In the retrospective analysis, women were classified as potential high-responders if initial AMH was in the uppermost quartile (75th percentile) of the observed AMH distribution. In both protocols, the 75th percentile was identical (5.0 ng/ml = 37.4 pmol/l). In the retrospective analysis, one hundred fifty-five women treated in the long GnRH agonist protocol (76 and 79 in the HP-hMG and rFSH groups, respectively) and 188 women in the GnRH antagonist protocol (87 and 101 in the HP-hMG and rFSH groups, respectively) were classified as potential high-responders.

In each protocol, baseline characteristics, end-of-stimulation data, ovarian response and embryo data were compared between the women grouped according to their AMH value on stimulation day 1 (>75th versus ≤75th percentile). Similar analyses were performed for the potential high-responders comparing gonadotropin treatments (HP-hMG versus rFSH) within each protocol. Continuous and categorical data were compared using the Wilcoxon test and the Chi-Square or Fisher's exact test, respectively. For the potential high-responders, risk of high response (≥15 oocytes retrieved) and chance of live birth were compared between

treatments using the Chi-square test. The observed differences in live birth rates between gonadotropin-treatment groups were further analyzed in the pooled population of potential high-responders from both protocols to determine if they could be attributed to baseline characteristics or end-of-stimulation variables. For each variable, a logistic regression model was fitted including treatment group and the variable in question in the linear predictor. Only fresh treatment cycles were included in the present dataset.

5. Results

High AMH category versus non-high AMH category

In both the long agonist protocol and the antagonist protocol, the women in the high AMH category were characterized by younger age, longer menstrual cycle length, higher AFC, lower FSH and larger ovarian volume at start of stimulation than women in the non-high AMH category ($p \leq 0.003$ for each variable). These features are shown in Table 1.

Table 1. Demographics and baseline, end-of-stimulation, oocyte and embryo data of the women grouped by the AMH concentration at start of stimulation (quartiles 1-3 versus quartile 4).

Variable	Long GnRH agonist protocol			GnRH antagonist protocol		
	AMH Q1-Q3	AMH Q4		AMH Q1-Q3	AMH Q4	
	$\leq 75^{\text{th}}$	$> 75^{\text{th}}$	p	$\leq 75^{\text{th}}$	$> 75^{\text{th}}$	p
	(≤ 5.2 ng/ml)	(> 5.2 ng/ml)	Value*	(≤ 5.2 ng/ml)	(> 5.2 ng/ml)	Value*
	($n = 468$)	($n = 155$)		($n = 561$)	($n = 188$)	
Clinical characteristics						
Age (years)	31 (29, 34)	30 (28, 32)	<0.001	31 (29, 33)	30 (28, 32)	<0.001
BMI (kg/m^2)	21.9 (20.3, 24.0)	21.3 (20.1, 23.5)	0.113	21.9 (20.3, 23.8)	21.8 (20.5, 23.5)	0.868
Cycle length (days)	28 (28, 29)	29 (28, 30)	<0.001	28 (28, 29)	29 (28, 30)	<0.001
First treatment cycle, n (%)	327 (70%)	104 (67%)	0.517	427 (76%)	134 (71%)	0.186
Day 1 (before stimulation)						
Ovarian volume (ml)	8.5 (6.0, 11.8)	10.4 (7.7, 14.3)	<0.001	10.6 (8.0, 14.2)	13.2 (9.6, 16.8)	<0.001
AFC (n)	10 (7, 14)	11 (8, 18)	<0.001	14 (11, 17)	18 (15, 22)	<0.001
AMH (ng/ml)	3.0 (2.1, 4.0)	7.0	<0.001	2.4	6.9	<0.001

Variable	Long GnRH agonist protocol			GnRH antagonist protocol		
	AMH Q1-Q3	AMH Q4	<i>p</i> Value*	AMH Q1-Q3	AMH Q4	<i>p</i> Value*
	≤75th	>75th		≤75th	>75th	
	(≤5.2 ng/ml)	(>5.2 ng/ml)		(≤5.2 ng/ml)	(>5.2 ng/ml)	
	(<i>n</i> = 468)	(<i>n</i> = 155)		(<i>n</i> = 561)	(<i>n</i> = 188)	
		(5.8, 8.5)		(1.4, 3.6)	(6.0, 8.7)	
FSH (IU/l)	3.8 (3.0, 4.9)	3.4 (2.7, 4.4)	0.003	7.2 (6.2, 8.5)	6.5 (5.7, 7.6)	<0.001
End-of-stimulation						
Estradiol (nmol/l)	5.5 (4.0, 7.3)	8.5 (6.2, 13.0)	<0.001	5.7 (4.1, 8.2)	8.7 (6.3, 13.3)	<0.001
Progesterone (nmol/l)	2.6 (2.0, 3.4)	3.2 (2.4, 3.9)	<0.001	2.5 (1.9, 3.2)	2.9 (2.1, 3.8)	<0.001
Progesterone/estradiol ratio	0.46 (0.35, 0.63)	0.36 (0.24, 0.49)	<0.001	0.42 (0.30, 0.60)	0.32 (0.21, 0.44)	<0.001
Follicles ≥12 mm (<i>n</i>)	10 (8, 13)	15 (12, 19)	<0.001	10 (7, 13)	15 (11, 18)	<0.001
Endometrial thickness (mm)	11 (9, 12)	11 (10, 12)	0.079	10 (9, 12)	11 (10, 12)	0.039
Endometrial echogenicity pattern (hypo, iso, hyper) (%)	39, 49, 13	34, 51, 15	0.544	40, 51, 9	36, 54, 10	0.668
Cycle cancellation for ovarian hyper-response, <i>n</i> (%)	2 (<1%)	7 (5%)	0.001	1 (<1%)	1 (<1%)	0.439
Early OHSS (moderate/severe), <i>n</i> (%)	1 (<1%)	7 (5%)	<0.001	4 (<1%)	8 (4%)	0.003
Intervention for ovarian hyper-response, <i>n</i> (%)	2 (<1%)	11 (7%)	<0.001	16 (3%)	19 (10%)	<0.001
Oocyte retrieval						
Women with oocyte retrieval, <i>n</i> (%)	446 (95%)	145 (94%)	0.392	537 (96%)	185 (98%)	0.088
Oocytes retrieved (<i>n</i>)	9 (6, 12)	14 (10, 18)	<0.001	8 (5, 11)	12 (9, 17)	<0.001
Women with ≥15 oocytes retrieved, <i>n</i> (%)	76 (16%)	65 (42%)	<0.001	63 (11%)	76 (40%)	<0.001
Fertilization and embryo data						
Fertilisation rate (%)	60 (33, 75)	52 (29, 70)	0.091	60 (43, 75)	58 (42, 71)	0.193
Embryos, day 3 (<i>n</i>)	2 (1, 5)	3 (2, 6)	0.029			
Women with top-quality	199 (45%)	73 (50%)	0.229			

Variable	Long GnRH agonist protocol			GnRH antagonist protocol		
	AMH Q1-Q3	AMH Q4	<i>p</i>	AMH Q1-Q3	AMH Q4	<i>p</i>
	≤75th	>75th		≤75th	>75th	
	(≤5.2 ng/ml)	(>5.2 ng/ml)		(≤5.2 ng/ml)	(>5.2 ng/ml)	
	(<i>n</i> = 468)	(<i>n</i> = 155)	Value*	(<i>n</i> = 561)	(<i>n</i> = 188)	Value*
embryo(s), day 3, <i>n</i> (%)†						
Blastocysts, day 5 (<i>n</i>)				2 (1, 4)	3 (1, 6)	<0.001
Women with good-quality blastocyst(s), day 5, <i>n</i> (%)‡				266 (50%)	106 (57%)	0.068
Women with transfer, <i>n</i> (%)¶	397 (89%)	122 (84%)	0.119	462 (86%)	159 (86%)	0.976

Values are median (IQR) unless otherwise indicated.

*Wilcoxon test (continuous data); Chi-Square test or Fisher's exact test (categorical data).

†Top-quality embryos were defined as 4-5 cells on day 2, ≥7 cells on day 3, equally-sized blastomeres and ≤20% fragmentation on day 3 and no multinucleation.

‡Good-quality blastocysts were defined as blastocysts with expansion and hatching score ≥4 and with inner cell mass and trophoctoderm grades of A or B, using the definitions described by Gardner & Schoolcraft, "In-vitro culture of human blastocysts," In TOWARDS REPRODUCTIVE CERTAINTY: FERTILITY AND GENETICS BEYOND 1998, Jansen & Mortimer, eds. (The Parthenon Publishing Group, New York 1999), pg. 378-88.

¶Among women with oocytes retrieved.

The retrospective analysis revealed that, independent of the protocol used, women with high AMH exhibited significantly ($p < 0.001$ for each variable) higher serum levels of estradiol and progesterone as well as increased number of growing follicles ≥ 12 mm at end of stimulation. Further, the women with high AMH had significantly ($p \leq 0.003$ for each variable) more oocytes retrieved, increased occurrence of high response, higher frequency of early OHSS and interventions for hyper-response. In the long agonist protocol, cycle cancellation due to ovarian hyper-response occurred more frequently among women in the high AMH category ($p = 0.001$). At end of stimulation, no clinically relevant differences were noted in endometrial thickness or echogenicity patterns between the two AMH categories. Significantly more embryos on day 3 (long agonist protocol: $p = 0.029$) or blastocysts on day 5 (antagonist protocol: $p < 0.001$) were available in women with high AMH, but the proportion of women with top-quality embryo(s) or good-quality blastocyst(s) were similar in the two AMH categories.

6. HP-hMG Versus rFSH Stimulation in High AMH Category

Within each protocol, there were no clinically relevant differences between the two gonadotropin-treatment groups in the high AMH category regarding demographics, fertility history and markers of ovarian reserve, as shown in Table 2 below. BMI was significantly lower in rFSH-treated women, but was not believed to be of clinical relevance. (However, it is possible that a higher BMI could blunt ovarian response.) At the end of stimulation, higher estradiol levels ($p = 0.012$) and lower progesterone levels ($p < 0.001$) were observed with HP-hMG in the antagonist and long agonist protocol, respectively.

Table 2. Comparison of baseline, end-of-stimulation, oocyte and embryo characteristics between HP-hMG- and rFSH-treated women with potential for being high-responders by a high AMH at start of stimulation.

Variable	Long GnRH agonist protocol			GnRH antagonist protocol		
	AMH Q4: >75th (>5.2 ng/ml)			AMH Q4: >75th (>5.2 ng/ml)		
	HP-hMG (<i>n</i> = 76)	rFSH (<i>n</i> = 79)	<i>p</i> Value*	HP-hMG (<i>n</i> = 87)	rFSH (<i>n</i> = 101)	<i>p</i> Value*
Clinical characteristics						
Age (years)	30 (28, 32)	30 (28, 32)	0.743	30 (28, 33)	30 (28, 31)	0.039
BMI (kg/m ²)	22.5 (20.7, 23.8)	20.8 (19.8, 22.8)	0.002	22.1 (21.0, 23.9)	21.6 (20.1, 23.0)	0.022
Cycle length (days)	29 (28, 30)	29 (28, 30)	0.682	29 (28, 30)	29 (28, 31)	0.382
First treatment cycle, <i>n</i> (%)	52 (68%)	52 (66%)	0.731	57 (66%)	77 (76%)	0.105
Day 1 (before start of stimulation)						
Ovarian volume (ml)	10.3 (7.9, 13.9)	10.5 (7.7, 14.8)	0.807	13.4 (9.1, 17.0)	13.0 (9.9, 16.7)	0.885
AFC (<i>n</i>)	12 (8, 20)	11 (8, 16)	0.486	18 (15, 22)	18 (15, 22)	0.934
AMH (ng/ml)	7.0 (5.9, 8.5)	7.0 (5.7, 8.4)	0.912	7.1 (6.2, 8.7)	6.8 (6.0, 8.3)	0.347
FSH (IU/l)	3.2 (2.6, 4.4)	3.6 (2.8, 4.4)	0.257	6.7 (5.6, 7.7)	6.4 (5.7, 7.5)	0.251
End-of-stimulation						
Estradiol (nmol/l)	8.7 (6.4, 13.0)	8.4 (6.1, 12.8)	0.736	9.7 (6.8, 14.8)	7.8 (5.5, 12.4)	0.012
Progesterone (nmol/l)	2.7 (1.9, 3.6)	3.6 (2.8, 4.5)	<0.001	2.8 (2.1, 3.9)	3.0 (2.1, 3.8)	0.857
Progesterone/estradiol ratio	0.31 (0.21, 0.42)	0.43 (0.30, 0.52)	<0.001	0.26 (0.20, 0.41)	0.34 (0.24, 0.47)	0.011
Follicles ≥12 mm (<i>n</i>)	15 (12, 18)	16 (13, 19)	0.274	14 (11, 18)	16 (12, 19)	0.064
Endometrial thickness (mm)	11 (10, 12)	11 (10, 12)	0.522	11 (10, 12)	11 (10, 12)	0.478
Endometrial echogenicity pattern (hypo, iso, hyper) (%)	44, 43, 13	24, 60, 17	0.033	31, 58, 11	41, 50, 9	0.386
Cycle cancellation for ovarian hyper-response, <i>n</i> (%)	3 (4%)	4 (5%)	1.000	0 (0%)	1 (<1%)	–
Early OHSS	3 (4%)	4 (5%)	1.000	3 (3%)	5 (5%)	0.727

Variable	Long GnRH agonist protocol			GnRH antagonist protocol		
	AMH Q4: >75th (>5.2 ng/ml)			AMH Q4: >75th (>5.2 ng/ml)		
	HP-hMG (<i>n</i> = 76)	rFSH (<i>n</i> = 79)	<i>p</i> Value*	HP-hMG (<i>n</i> = 87)	rFSH (<i>n</i> = 101)	<i>p</i> Value*
(moderate/severe), <i>n</i> (%)						
Intervention for ovarian hyper-response, <i>n</i> (%)	5 (7%)	6 (8%)	1.000	7 (8%)	12 (12%)	0.470
Oocyte retrieval						
Women with oocyte retrieval, <i>n</i> (%)	72 (95%)	73 (92%)	0.555	85 (98%)	100 (99%)	0.475
Oocytes retrieved (<i>n</i>)	12 (9, 16)	15 (11, 20)	0.007	12 (8, 15)	14 (10, 19)	0.033
Women with ≥ 15 oocytes retrieved, <i>n</i> (%)	25 (33%)	40 (51%)	0.025	27 (31%)	49 (49%)	0.015
Fertilisation and embryo data						
Fertilisation rate (%)	50 (27, 73)	56 (35, 69)	0.826	57 (43, 69)	60 (41, 73)	0.663
Embryos on day 3 (<i>n</i>)	3 (2, 6)	4 (2, 6)	0.806			
Women with top-quality embryo(s) on day 3, <i>n</i> (%)†	38 (53%)	35 (48%)	0.561			
Blastocysts on day 5 (<i>n</i>)				3 (1, 6)	3 (1, 6)	0.969
Women with good-quality blastocyst(s) on day 5, <i>n</i> (%)‡				55 (65%)	51 (51%)	0.060
Women with transfer, <i>n</i> (%)¶	61 (85%)	61 (84%)	0.848	72 (85%)	87 (87%)	0.655

Values are median (IQR) unless otherwise indicated.

*Wilcoxon test (continuous data); Chi-Square test or Fisher's exact test (categorical data).

†Top-quality embryos were defined as 4-5 cells on day 2, ≥7 cells on day 3, equally-sized blastomeres and ≤20% fragmentation on day 3 and no multinucleation.

‡Good-quality blastocysts were defined as blastocysts with expansion and hatching score ≥4 and with inner cell mass and trophectoderm grades of A or B, using the definitions described by Gardner & Schoolcraft, *supra*.

¶Among women with oocytes retrieved.

The retrospective analysis revealed that HP-hMG was associated with a lower median number of oocytes retrieved in women with high AMH as compared with rFSH (long agonist protocol: -3 oocytes, $p = 0.007$; antagonist protocol: -2 oocytes, $p = 0.033$). In both protocols, the percentage of women with a high ovarian response was significantly lower for HP-hMG compared with rFSH (long agonist protocol: 33% versus 51%, $p = 0.025$; antagonist protocol:

31% versus 49%, $p = 0.015$) (*see* Figure 1A). Therefore, the risk of high response was reduced with HP-hMG by 35 and 37%, respectively. There were no apparent differences between the two gonadotropin groups concerning cycle cancellations due to excessive response, early moderate/severe OHSS or interventions for excessive response in either protocol.

Within each protocol, fertilization rate, number of embryos/blastocysts available for transfer, women with top-quality embryo(s)/good-quality blastocyst(s) and percentages of women with transfer were similar between the HP-hMG and rFSH groups in the high AMH category. However, in both protocols a statistical trend ($p < 0.10$) for improved live birth rate per started cycle was observed for HP-hMG compared with rFSH (*see* Figure 1B). When restricted to women with embryo transfer, the difference in live birth rate between HP-hMG and rFSH was statistically significant ($p = 0.043$) in the antagonist protocol.

When the data of women with high AMH from both protocols were integrated, HP-hMG treatment was associated with significantly lower incidence of high response (32% (52/163) versus 49% (89/180), $p < 0.001$) and increased live birth rate per started cycle (34% (55/163) versus 22% (39/180), $p = 0.012$) as well as per embryo transfer cycle (41% (55/133) versus 26% (39/148), $p = 0.008$) compared with rFSH treatment. The logistic regression analysis (Table 3 below) indicated that the type of GnRH protocol did not explain the difference in live birth rates between HP-hMG and rFSH, as it remained significant ($p = 0.012$) in the adjusted analysis. The probability of a live birth significantly increased with the availability of a top-quality embryo/good-quality blastocyst for transfer ($p < 0.001$), while an increased progesterone level ($p = 0.042$) and increased progesterone/estradiol ratio ($p = 0.042$) at end of stimulation significantly decreased the probability of live birth (Table 3 below). However, in all adjusted analyses the difference between the two gonadotropin preparations remained significant ($p < 0.05$) indicating that the higher live birth rate in women with high AMH and stimulated with HP-hMG could not be attributed to differences in the baseline and end-of-stimulation variables examined.

Table 3. Logistic regression analysis of live birth rate adjusting for baseline characteristics or end-of-stimulation variables.

Variables	Overall population of potential high-responders (<i>n</i> = 343)	
	OR [95% CI]	P-value ^a
Adjusting for type of stimulation protocol		
Antagonist protocol vs. long agonist protocol	1.11 [0.69; 1.80]	0.666
HP-hMG vs. rFSH	1.85 [1.14; 2.99]	0.012
Adjusting for age		
Age (years)	1.00 [0.92; 1.09]	0.975
HP-hMG vs. rFSH	1.84 [1.14; 2.98]	0.013
Adjusting for BMI		
BMI (kg/m ²)	1.03 [0.92; 1.15]	0.579
HP-hMG vs. rFSH	1.79 [1.10; 2.92]	0.020
Adjusting for menstrual cycle length		
Cycle length (days)	1.05 [0.92; 1.19]	0.500
HP-hMG vs. rFSH	1.84 [1.14; 2.98]	0.013
Adjusting for first treatment cycle		
First treatment cycle	1.09 [0.65; 1.85]	0.737
HP-hMG vs. rFSH	1.85 [1.14; 2.99]	0.012
Adjusting for total number of follicles on stimulation day 1		
Total number of follicles	0.99 [0.96; 1.02]	0.435
HP-hMG vs. rFSH	1.89 [1.16; 3.07]	0.010
Adjusting for FSH on stimulation day 1		
FSH (IU/l)	1.10 [1.00; 1.21]	0.060
HP-hMG vs. rFSH	1.89 [1.16; 3.06]	0.010
Adjusting for estradiol at end-of-stimulation		
Estradiol (nmol/l)	0.99 [0.96; 1.03]	0.716
HP-hMG vs. rFSH	1.85 [1.14; 3.01]	0.013
Adjusting for progesterone at end-of-stimulation		
Progesterone (nmol/l)	0.84 [0.71; 0.99]	0.042
HP-hMG vs. rFSH	1.76 [1.08; 2.87]	0.024

Variables	Overall population of potential high-responders (n = 343)	
	OR [95% CI]	P-value ^a
Adjusting for progesterone/estradiol at end-of-stimulation		
Progesterone/estradiol	0.26 [0.07; 0.95]	0.042
HP-hMG vs. rFSH	1.68 [1.02; 2.75]	0.040
Adjusting for number of follicles ≥ 12 mm at end-of-stimulation		
Follicles ≥ 12 mm	1.05 [0.99; 1.10]	0.094
HP-hMG vs. rFSH	1.93 [1.18; 3.16]	0.008
Adjusting for endometrial thickness at end-of-stimulation		
Endometrial thickness (mm)	0.97 [0.85; 1.10]	0.653
HP-hMG vs. rFSH	1.84 [1.13; 2.99]	0.014
Adjusting for number of oocytes retrieved		
Number of oocytes retrieved	1.00 [0.96; 1.04]	0.973
HP-hMG vs. rFSH	1.85 [1.13; 3.02]	0.014
Adjusting for top-quality embryo(s)/good-quality blastocyst(s) on transfer day		
≥ 1 Top-quality embryo/good-quality blastocyst	2.61 [1.48; 4.61]	<0.001
HP-hMG vs. rFSH	1.80 [1.08; 3.00]	0.025

OR = odds ratio; CI = Wald confidence interval

^aTwo-sided Wald test of OR = 1 (no effect).

These results show that the prevalence of patients with a high ovarian response (i.e. ≥ 15 oocytes retrieved) was approximately three times higher in women with high AMH (≥ 5.2 ng/ml) than in women in the non-high AMH category in both the long GnRH agonist and GnRH antagonist protocol. Although women with high AMH showed ovarian hyper-response in both the antagonist and long agonist protocols, ovarian stimulation with HP-hMG was associated with a substantially lower high-response rate than stimulation with rFSH. Hence, the risk of developing a high response where an excessive response is predicted may be reduced by approximately one third by using HP-hMG instead of FSH for controlled ovarian stimulation, even in the GnRH antagonist protocol.

Without being bound by any theory, it is possible that the more moderate ovarian response with HP-hMG, and the consequently reduced risk of hyper-response with HP-hMG compared with rFSH, may be attributed at least in part to the different FSH isoform profiles of HP-hMG and rFSH, which may influence the *in vivo* biopotency in humans and thereby the rate of high ovarian response among the potential high-responders. Other contributing factors may be the LH activity provided by HP-hMG that is not present in rFSH, and the post-menopausal FSH isoform profile found in the FSH activity of HP-hMG.

The logistic regression analyses in the overall population did not identify any specific variable(s) that explained the different live birth rates between HP-hMG and rFSH stimulation, but indicated that progesterone levels and progesterone/estradiol ratios at the end of stimulation and the availability of top-quality embryos/good-quality blastocysts (as assessed morphologically; aneuploidy was not assessed) influenced live birth rates.

The applicants have found that visual assessment of oocyte/embryo on day three following retrieval [see e.g. Ziebe *et al.*, *Human Reproduction* 22(9) 2404-13 (2007)] does not give any indication of aneuploidy. Indeed, the applicants have found that it is not unusual for the “best looking” oocyte/embryo (based on visual assessment at day three) to be found to be aneuploid (following chromosomal analysis/genetic screening), and lead to an unsuccessful outcome. There is therefore a need for a technique which increases the likelihood of developing euploid blastocysts (decreases the proportion/percentage of aneuploid blastocysts), so as to reduce the emphasis on visual assessment of oocyte/embryo.

Further analysis of the results suggested to the inventors that the use of HP-hMG for controlled ovarian stimulation has a direct effect on improved oocyte quality and may reduce aneuploidy rate, and indicate that progesterone, progesterone/estradiol ratio and embryo quality play a role in treatment outcome in patients at risk of hyper-response based on high serum AMH levels.

Example 2 – Prospective Clinical Trial

A randomized, assessor-blind phase IV clinical trial comparing HP- hMG and rFSH in a GnRH antagonist cycle with compulsory single-blastocyst transfer in a high responder subject population is planned for the United States. The aim of this study is to demonstrate the HP-hMG is at least non-inferior to rFSH with respect to ongoing pregnancy rate (OPR) in potential high-responders undergoing IVF/ICSI treatment. Subjects will be prospectively classified as potential high ovarian responders based on a serum level of AMH ≥ 5.0 ng/ml (e.g. ≥ 5.2 ng/ml) by the Beckmann-Coulter Gen 2 assay as described in Arce *et al.*, *Fertility and Sterility* 99: 1644-53 (2013), using a single reference laboratory (ReproSource, Inc., Woburn, MA) utilizing materials and reagents from the Beckman Coulter-DSL assay (Chaska, MN).

The phase IV, randomized, open-label, assessor-blind, parallel-group, multicenter study will be conducted at approximately 25-30 infertility centers in the United States. Approximately 600 females will be enrolled. Subjects are to be from age 21 up to age 36 years with regular ovulatory menstrual cycles of 21 to 35 days, even up to 45 days (21 to 45 days), with a body mass index (BMI) between 18 and 32 kg/m², or 18 and 30 kg/m², unexplained or mild male factor infertility for a period of ≥ 1 year, eligible for ICSI according to the investigator, and AMH ≥ 5.0 ng/ml (e.g. ≥ 5.2 ng/ml). Additional inclusion criteria may be having an AFC ≥ 10 , ≥ 15 , ≥ 18 or ≥ 20 in both ovaries combined. Key exclusion criteria include endometriosis stage I-IV, severe male factor infertility, polycystic ovary syndrome (PCOS), and previous poor response to a COS cycle. Additional exclusion criteria may be having an AFC < 8 or < 10 in both ovaries combined.

The basic protocol is outline in Figure 2. Optionally, combination oral contraceptive pills (COCPs) started in the previous menstrual cycle will be continued for a maximum of 21 days. Subjects will be randomized 1:1 to undergo COS with either HP-hMG or rFSH in a GnRH antagonist cycle. After discontinuing the COCPs, gonadotropins (either HP-hMG or rFSH) will be started on the 3rd day of withdrawal bleeding but no sooner than the 5th day after discontinuation of COCPs. The gonadotropin dose will be initiated at 150 IU for the first

5 days. From Stimulation Day 6 onward, based on follicular response assessed by TVUS, dosing can be adjusted every day as needed by 75 IU per adjustment. However, the maximum gonadotropin dose will be 300 IU/day; gonadotropin dosing can continue for a maximum of 20 days. Coasting is prohibited.

When the lead follicle is > 14 mm in diameter, the GnRH antagonist (ganirelix acetate) will be initiated at a daily dose of 0.25 mg and continued throughout the gonadotropin treatment period. A single injection of 250 µg hCG (choriogonadotropin alfa) will be administered to induce final follicular maturation as soon as 3 follicles of ≥ 17 mm diameter are observed on TVUS. If a subject has >25 follicles, she will receive a GnRH agonist trigger and all resultant blastocysts will be vitrified after trophoectoderm biopsy, with no fresh embryo transfer to decrease risk of OHSS.

Oocyte retrieval will take place roughly 36 hours after hCG administration. Oocytes will be inseminated using partner sperm by ICSI 4±1 hours after retrieval. Oocyte, embryo and blastocyst quality will be assessed daily for 5 days following oocyte retrieval. On Day 5 following ICSI, a single blastocyst of the best quality available will be transferred; all remaining blastocysts will be frozen using the vitrification method.

Trophoectoderm (TE) biopsy for preimplantation genetic screening (PGS), optionally with next generation sequencing (NGS) technology, will be done with laser on Day 5 or Day 6 of expanded blastocyst, but results will not be used to determine selection of a blastocyst for fresh transfer.

The day after oocyte retrieval, vaginal progesterone inserts (100 mg twice aday – Endometrin®; Ferring) will be initiated for luteal phase support and will continue until the day of the β -hCG test (10 to 15 days after blastocyst/embryo transfer). Luteal support may be continued until ongoing pregnancy is confirmed.

Biochemical pregnancy will be confirmed by a positive β -hCG approximately 2 weeks after blastocyst transfer. Clinical pregnancy will be confirmed by TVUS indicating at least one

intrauterine gestational sac with fetal heart beat at 5 to 6 weeks gestation. Ongoing pregnancy will be confirmed by at least one intrauterine viable fetus at 10 to 11 weeks gestation.

For subjects with no ongoing pregnancy in the fresh cycle, single frozen blastocyst transfers can be initiated within 1 year of each subject's start of treatment. PGS results will be used to select the euploid blastocysts for frozen transfer. Frozen-thawed embryo replacement cycle data will be collected, including blastocyst transfer information, β -hCG test, clinical pregnancy, and ongoing pregnancy

Post-trial follow-up will include collection of delivery information (live birth and neonatal health), which will be collected for all subjects with an ongoing pregnancy in the fresh cycle or the 1-year post-randomization frozen-thawed embryo replacement cycles. Live birth rate after the fresh cycle and cumulative live birth rate after fresh and 1-year post-randomization frozen-thawed embryo replacement cycles will be evaluated as part of the post-trial follow-up.

The HP-hMG used will be Menopur, provided as a vial with powder (75 IU FSH activity and 75 IU LH activity) and 2 pre-filled syringes with solvent (each containing 1.1 mL). After reconstitution, each vial delivers 75 IU of FSH activity and 75 IU of LH activity.

The FSH used will be recombinant FSH (GONAL-F), provided as pen and cartridges filled with either 300, 450 or 900 IU FSH activity/1.08 mL solution for injection.

The other drugs used will be:

- Ganirelix Acetate Injection, manufactured by Merck, provided as a pre-filled syringe (0.5 mL) delivering 0.25 mg ganirelix. A daily dose of 0.25 mg will be continued throughout the gonadotropin treatment period.
- Ovidrel (choriogonadotropin alfa), manufactured by EMD Serono, provided as a pre-filled syringe (0.5 mL) delivering 250 μ g choriogonadotropin alfa, to be administered as a single injection as soon as 3 follicles of ≥ 17 mm diameter are observed on TVUS.

- Endometrin (progesterone), manufactured by Ferring, will be provided as capsules to be administered vaginally 2 times daily, each delivering 100 mg of progesterone (200 mg/day).

The primary end point is ongoing pregnancy rate, defined as presence of at least one intrauterine pregnancy with a viable fetus with a detectable fetal heartbeat at 10–11 weeks gestation. Secondary endpoints include:

- biochemical pregnancy rate (positive β -hCG)
- clinical pregnancy rate (transvaginal ultrasonography showing at least one intrauterine gestational sac with fetal heart beat at 5–6 weeks gestation)
- Early pregnancy loss (defined as 2 positive β -hCG tests but no ongoing pregnancy at 10-11 weeks gestation in the fresh cycle.)
- live birth rate
- follicular development as assessed by TVUS, Follicle level (Total number of follicles, Number of follicles ≤ 9 mm, 10-11 mm, 12-14 mm, 15-16 mm, and ≥ 17 mm) and subject level (largest follicle size, average follicle size, average size of 3 largest follicles, and average number of follicles ≥ 17 mm, ≥ 15 mm, and ≥ 12 mm).
- endocrine profile (serum estradiol [E2], progesterone [P4], hCG, LH)
- oocytes retrieved, fertilization rate, and embryo quality

The number of oocytes retrieved, the number of metaphase II oocytes, and the number of normally fertilized (2PN) oocytes will be summarized by frequency distribution and by descriptive statistics for each treatment group.

The oocyte maturity stage will be assessed prior to undergoing ICSI. Maturity stage will be categorized as germinal vesicle, metaphase I, metaphase II, degenerated, or other.

The fertilization rate will be expressed as a percentage for each subject and calculated as 100 times the ratio of the number of fertilized 2PN oocytes to the number of oocytes retrieved.

The quality of embryos 3 days after oocyte retrieval will be assessed by cleavage stage, blastomere uniformity, cell size, the degree of fragmentation, and visual signs of multinucleation.

The quality of blastocysts 5 days after oocyte retrieval will be assessed by blastocyst expansion and hatching status, blastocyst inner cell mass grading, and trophectoderm grading. Frequency distributions will be provided for each treatment group at the blastocyst level. The best quality blastocyst 5 days after oocyte retrieval at the subject level will be summarized for excellent-quality blastocysts and good-quality blastocysts separately by treatment using descriptive statistics.

- aneuploidy rate

The aneuploidy rate will be expressed as a percentage for each subject and calculated as 100 times the ratio of the number of aneuploid blastocysts to the total number of blastocysts. The number of aneuploid blastocysts may be determined e.g. by the methods described above (e.g. chromosomal analysis such as PGS, CCS).

- endometrial assessment by TVUS

Endometrial thickness and the echogenicity pattern will be summarized by frequency distribution and by descriptive statistics, as appropriate, for each treatment group at stimulation Day 6, the last day of stimulation, and at the time of blastocyst transfer in the fresh cycle.

Embryo and Blastocyst testing.

Number and Quality of Embryos on Day 3

Each embryo will be evaluated on Day 3 post-insemination. The quality evaluation will consist of assessment of cleavage stage and embryo morphology parameters (blastomere uniformity, cell size, degree of fragmentation, and visual signs of multinucleation).

Cleavage stage will be defined by the number of blastomeres.

Blastomere uniformity will be classified as equally sized blastomeres or unequally sized blastomeres (largest blastomere >25% larger in average diameter compared to the smallest blastomere).

Cell size will be classified as stage-specific cell size or not stage-specific cell size.

Degree of fragmentation will be classified as 1 of the following: 0%, 1-10%, 11-20%, 21-25%, 26-30%, 31-50%, or >50% fragmentation, or totally fragmented (no blastomeres recognized).

Visual sign of multinucleation will be evaluated as a yes or no.

Number and Quality of Blastocysts on Day 5

Blastocyst Expansion and Hatching Status, Blastocyst Inner Cell Mass Grading, and Trophectoderm Grading

The quality evaluation of blastocysts on Day 5 after oocyte retrieval will consist of assessment of 3 parameters: blastocyst expansion and hatching status, blastocyst inner cell mass grading, and trophectoderm grading. The scoring is based on the classification system by Gardner & Schoolcraft, 1999 [Gardner DK, Schoolcraft WB. In vitro culture of human blastocysts. In: Towards reproductive certainty (Eds Jansen R & Mortimer D). The plenary proceedings of the 11th world congress on in vitro fertilization and human reproductive genetics. The Parthenon Publishing Group. 1999. 378- 88.], with the addition of D-categories for inner cell mass and trophectoderm.

Blastocyst expansion and hatching status will be assessed as 1 of the following:

- 1: An early blastocyst, blastocoel being less than half volume of that of the embryo.
- 2: A blastocyst with a blastocoel whose volume is half of, or greater than half of, that of the embryo.
- 3: A blastocyst with a blastocoel completely filling the embryo.
- 4: An expanded blastocyst with a blastocoel volume larger than that of the early embryo, with a thinning zona.
- 5: A hatching blastocyst with the trophectoderm starting to herniate through the zona.
- 6: A hatched blastocyst, in which the blastocyst has completely escaped from the zona.

For blastocysts with expansion and hatching status 3-6, blastocyst inner cell mass grading and trophectoderm grading will be evaluated.

Blastocyst inner cell mass grading will be assessed as 1 of the following:

A: Tightly packed, many cells.

B: Loosely grouped, several cells.

C: Very few cells.

D: Degenerative or no inner cell mass.

Trophectoderm grading will be assessed as 1 of the following:

A: Many cells forming a cohesive epithelium.

B: Few cells forming a loose epithelium.

C: Very few, large cells.

D: Degenerative or very large cells.

Blastocysts with expansion and hatching status 3-6 will have a score combining the 3 parameters (blastocyst expansion and hatching status, inner cell mass, and trophectoderm); e.g., 4AB for a blastocyst with blastocyst expansion and hatching status 4, inner cell mass grading A, and trophectoderm grading B.

Overall Blastocyst Quality on Day 5

The overall blastocyst quality on Day 5 is based on the blastocyst expansion and hatching status, inner cell mass grading, and trophectoderm grading.

Excellent-quality blastocysts are defined as those with blastocyst expansion and hatching status 4, 5, or 6, inner cell mass grading A, and trophectoderm grading A or B. The number and percentage of excellent-quality blastocysts on Day 5 is a secondary endpoint. This will be based on the best overall quality score of the Day 5 post-insemination assessments.

Good-quality blastocysts are defined as those with blastocyst expansion and hatching status 3, 4, 5, or 6, inner cell mass grading A or B, and trophectoderm grading A or B. The number and percentage of good-quality blastocysts on Day 5 will be based on the best overall quality score.

The number and percentage of excellent-quality blastocysts and good-quality blastocysts on Day 5 will be calculated. The best blastocyst based on Day 5 morphology will be transferred.

Compaction Assessment in Morulas

Embryos that have not reached the blastocyst stage on Day 5, but are morulas, will also be evaluated. Morulas will be categorized as 1 of the following 3 options:

Compacted: complete compaction. Tightly compacted cells. Individual cell membranes are no longer visible.

Compacting: early stage. Cells can be distinguished.

Abnormal compaction: regional or partial compaction, or few cells (<8) in compaction

Day 5 morulas may be considered for extended culture as per the investigator/site standard of care.

Day 6 embryos can then undergo trophectoderm biopsy and vitrification, or be discarded. The quality of Day 6 embryos should be assessed and recorded on the eCRF in a manner similar to that above.

The post-trial endpoints include:

Cumulative live birth rate for fresh and frozen blastocyst transfer (defined as the proportion of subjects with at least 1 viable live birth greater >21 weeks gestation);

Live birth rate for fresh blastocyst transfer (defined as the proportion of subjects with at least 1 viable live birth greater >21 weeks gestation);

Early pregnancy loss rate in frozen blastocyst transfer is defined as 2 positive β -hCG tests but no ongoing pregnancy at 10-11 weeks gestation in the frozen cycle;

Late pregnancy loss rate (defined as a confirmed ongoing pregnancy but no viable live birth greater >21 weeks gestation); and Positive β -hCG rate, clinical pregnancy rate, and ongoing pregnancy rate for frozen blastocyst transfers.

The present inventors believe that this study will show that stimulation of women at risk of a high ovarian response to controlled ovarian stimulation with HP-hMG improves embryo quality, increases the proportion of euploid blastocysts, decreases the proportion of aneuploid blastocysts, decreases aneuploidy rate, increases ongoing pregnancy rates and/or increases live birth rates, as compared to comparable methods using recombinant follicle stimulating hormone (rFSH) as the gonadotropin. For example, the present inventors believe that this

study will show that stimulation of women at risk of a high ovarian response to controlled ovarian stimulation with HP-hMG results in fewer eggs but a higher proportion of euploid blastocysts as compared to comparable methods using rFSH as the gonadotropin. Further, the present inventors believe that this study will show that stimulation of women at risk of a high ovarian response to controlled ovarian stimulation with HP-hMG results in fewer eggs but a lower aneuploidy rate compared to comparable methods using rFSH as the gonadotropin.

There have been disclosed hereinbefore the products methods defined by the following numbered paragraphs:

1. A method for improving the quality of an embryo produced by *in vitro* fertilization after controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml), when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

2. A method for improving the quality of an embryo produced by *in vitro* fertilization after controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising administering an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high ovarian response to controlled ovarian stimulation, wherein the selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml), when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

3. A method for increasing the proportion of euploid blastocysts produced by *in vitro* fertilization after controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

4. A method for increasing the percentage of euploid blastocysts produced by *in vitro* fertilization after controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising administering an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high response to controlled ovarian stimulation, wherein the selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

5. A method for treating infertility in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having (i) a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

6. A method for treating infertility in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising administering an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high ovarian response to controlled ovarian stimulation, wherein the

selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

7. A method for effecting controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

8. A method for effecting controlled ovarian stimulation in a woman at risk of a high ovarian response thereto, comprising administering an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high ovarian response to controlled ovarian stimulation, wherein the selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

9. A method for increasing ongoing pregnancy rates in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

10. A method for increasing ongoing pregnancy rates in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising administering an amount of

highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high ovarian response to controlled ovarian stimulation, wherein the selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

11. A method for increasing live birth rates in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising

selecting a woman at risk of a high ovarian response to controlled ovarian stimulation having a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method; and

administering to the selected woman an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development.

12. A method for increasing live birth rates in a woman at risk of a high ovarian response to controlled ovarian stimulation, comprising administering an amount of highly purified menotropin (HP-hMG) effective to stimulate follicle development to a woman selected as being at risk of a high ovarian response to controlled ovarian stimulation, wherein the selected woman has a serum anti-Müllerian hormone (AMH) level greater than or equal to 5.0 ± 0.5 ng/ml (e.g. $\geq 5.2 \pm 0.5$ ng/ml) when measured using a Beckmann-Coulter Gen 2 assay or a comparable AMH level measured by a different method.

13. The method of any one of the preceding paragraphs, wherein the woman has an antral follicle count (AFC) of greater than or equal to 10 in both ovaries combined, prior to stimulation.

14. The method of any one of paragraphs 1-12, wherein the woman has an antral follicle count (AFC) of greater than or equal to 15 in both ovaries combined, prior to stimulation.

15. The method of any one of paragraphs 1-12, wherein the method results in an increased proportion of euploid blastocysts as compared to a comparable method using recombinant follicle-stimulating hormone (rFSH) as the gonadotropin.

16. The method of any one of paragraphs 1-12, wherein the method results in an increased ongoing pregnancy rate.

17. The method of any one of paragraphs 1-12, wherein the method results in an increased live birth rate.

18. The method of any one of paragraphs 1-12, wherein the amount of HP-hMG administered is from 75-300 IU per day for from about 1 to about 20 days.

19. The method of any one of paragraphs 1-12, wherein the amount of HP-hMG administered is from 75-200 IU per day for from about 1 to about 20 days.

20. The method of any one of paragraphs 1-12, wherein the HP-hMG is administered for at least 5 days.

21. The method of any one of paragraphs 1-12, further comprising administering a gonadotropin hormone releasing hormone (GnRH) agonist.

22. The method of any one of paragraphs 1-12, further comprising administering a GnRH antagonist.

23. The method of any one of paragraphs 1-12, further comprising administering an amount of hCG effective to trigger ovulation.

24. The method of paragraph 23, further comprising harvesting oocytes from the woman.

25. The method of paragraph 25, further comprising *in vitro* fertilization of harvested oocytes.

26. The method of paragraph 25, wherein the *in vitro* fertilization comprises intracytoplasmic sperm injection (ICSI).

27. The method of any one of paragraphs 1-12, further comprising assessing the chromosomal quality of blastocysts obtained from the woman after *in vitro* fertilization of oocytes harvested from the woman.

28. The method of paragraph 27, further comprising blastocyst transfer of a blastocyst determined to be a euploid blastocyst.

29. The method of paragraph 28, wherein the transfer is fresh transfer.

30. The method of paragraph 27, further comprising freezing a blastocyst determined to be a euploid blastocyst.

Claims

1. A composition comprising menotropin for use in the treatment of infertility in a woman to thereby promote the development of euploid blastocysts for future blastocyst transfer, wherein the treatment comprises:
 - identifying a woman having a serum antimullerian hormone (AMH) level $\geq 5.2 \pm 0.5$ ng/ml and an antral follicle count (AFC) ≥ 10 in both ovaries combined prior to treatment/stimulation; and
 - that the hMG is to be administered at a daily dosage from day 1 to at least day 5 of treatment in a dose of 75 to 300 IU hMG to the identified woman.
2. A composition for use according to claim 1 wherein the treatment further comprises: that hCG is to be administered to trigger ovulation.
3. A composition for use according to any preceding claim wherein the menotropin is highly purified menotropin (HP-hMG).
4. A composition for use according to any preceding claim wherein the treatment comprises that the menotropin is to be administered at a daily dosage from day 1 to at least day 5 of treatment in a dose of 75 to 200 IU hMG to the identified woman.
5. A composition for use according to any preceding claim wherein the treatment comprises that the menotropin is to be administered at a daily dosage from day 1 to at least day 5 of treatment in a dose of 150 IU HP-hMG to the identified woman..
6. A composition for use according to any preceding claim wherein the treatment comprises that a GnRH antagonist is to be administered on day 6 of treatment.