UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Progesterone – Non-Oral

Program	Prior Authorization – Progesterone- Non-Oral
Medication	Crinone® (progesterone gel), Endometrin® (progesterone vaginal insert)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	5/2016
Pharmacy and Therapeutics Approval Date	3/2020
Effective Date	5/2020

1. Background:

This program is designed to provide coverage for non-infertility uses for all members.

2. Coverage Criteria:

A. <u>Non-Infertility</u>

1. **Crinone 4%, Crinone 8%, or Endometrin** will be approved based on the following criterion:

   a. Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)

   Authorization will be issued for 6 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Crinone package insert. Columbia Laboratories, Inc. Livingston, NJ. June 2017.
2. Endometrin package insert. Ferring Pharmaceuticals Inc. Parsippany, NJ. January 2018.

Program	Prior Authorization - Progesterone
Change Control	
Date	Change
5/2016	New program.
11/2016	Removed progesterone bulk powder and First Progesterone from policy
2/2017	Annual review. Updated template.
2/2018	Annual review. Added additional examples of non-infertility. Decreased non-infertility period to 6 months.
2/2019	Annual review. Updated references.
3/2020	Annual review, updated header.