

Clinical Pharmacy Program Guidelines for Progesterone - Oral

Program	Prior Authorization
Medication	Prometrium (progesterone micronized)
Markets in Scope	Arizona, California, Florida- CHIP, Hawaii, Maryland, New Mexico, Nevada, New York, New York EPP, Ohio, Rhode Island
Issue Date	9/2017
Pharmacy and Therapeutics Approval Date	4/2018
Effective Date	6/2018

1. Background:

Progesterone micronized is indicated for use in the prevention of endometrial hyperplasia in non-hysterectomized postmenopausal women who are receiving conjugated estrogen tablets. It also indicated for use in secondary amenorrhea.

2. Coverage Criteria:

<p>A. Criteria for Approval</p>	<p>1. Diagnosis of one of the following:</p> <ul style="list-style-type: none"> a. Amenorrhea b. Endometrial hyperplasia or prevention of endometrial hyperplasia c. Abnormal uterine or vaginal bleeding d. History of preterm birth e. Prevention of preterm delivery for current pregnancy <p style="text-align: center;">Authorization will be issued for 12 months.</p>
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3. References:

1. PROMETRIUM [package insert]. North Chicago, IL: AbbVie Inc.; 2017.

Program	Program type -
Change Control	
Date	Change

9/2017	New policy to accommodate Dx to Rx
12/2017	Added prevention of endometrial hyperplasia as an approvable diagnosis per request from state partner.
4/2018	Added history of preterm birth and prevention of preterm delivery for current pregnancy as approvable conditions.