UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Progesterone – Non-Oral

Program	Prior Authorization - Progesterone
Medication	Crinone® (progesterone gel), Endometrin® (progesterone vaginal insert)
Markets in Scope	Arizona, California, Florida-CHIP, Hawaii, Maryland, Nevada, New Mexico, New York, New York EPP, Ohio, Rhode Island
Issue Date	5/2016
Pharmacy and Therapeutics Approval Date	2/2018
Effective Date	4/2018

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. References:

1. Crinone package insert. Columbia Laboratories, Inc. Livingston, NJ. June 2017.
2. Endometrin package insert. Ferring Pharmaceuticals Inc. Parsippany, NJ. September 2016.

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.