UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Progesterone - Oral

Program	Prior Authorization
Medication	Prometrium (progesterone micronized)
Issue Date	9/2017
Pharmacy and Therapeutics Approval Date	12/2017
Effective Date	2/2018

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:

A. Criteria for Approval

1. Diagnosis of one of the following:

   a. Amenorrhea
   b. Endometrial hyperplasia or prevention of endometrial hyperplasia
   c. Abnormal uterine or vaginal bleeding

Authorization will be issued for 12 months.

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.

Confidential and Proprietary, © 2017 UnitedHealthcare Services Inc.