



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Name	2023 P 1022-11
Program	Prior Authorization/Notification - Contraceptives
Medication	Contraceptive Medications: medroxyprogesterone acetate (Depo-Provera <sup>®</sup> ), etonogestrel/ethinyl estradiol (NuvaRing <sup>®</sup> ), Oral Contraceptives, norelgestromin/ethinyl estradiol (OrthoEvra <sup>®</sup> ), Annovera <sup>®</sup> (segesterone/ethinyl estradiol), Twirla <sup>®</sup> (levonorgestrel/ethinyl estradiol)
P&T Approval Date	1/08, 4/09, 10/09, 11/10, 11/2011, 11/2012, 10/2013, 10/2014, 10/2015, 10/2016, 10/2017, 10/2018, 10/2019, 10/2020, 11/2021, 11/2022, 11/2023
Effective Date	2/1/2024

**1. Background:**

This program is designed for clients who are grandfathered and/or designated a Religious Exempt organization per the Patient Protection and Affordable Care Act and would like to exclude contraceptive products for contraception purposes.

**2. Coverage Criteria<sup>a</sup>:**

**A. Contraceptive medications** will be approved based on the following criterion:

1. Patient is using the medication for non-contraception purposes. Examples include:
  - a. Abnormal or excessive bleeding disorders (e.g.-Amenorrhea, oligomenorrhea, menorrhagia, dysfunctional uterine bleeding)
  - b. Acne
  - c. Decrease in bone mineral density
  - d. Dysmenorrhea
  - e. Endometriosis
  - f. Hirsutism
  - g. Irregular menses/cycles
  - h. Ovarian cysts
  - i. Perimenopausal symptoms
  - j. History of Pelvic Inflammatory Disease (PID)
  - k. Polycystic Ovarian Syndrome (PCO or PCOS)
  - l. Premenstrual Syndrome (PMS)
  - m. Premenstrual Dysphoric Disorder (PMDD)
  - n. Prevention of endometrial and/or ovarian cancer
  - o. Prevention of menstrual migraines
  - p. Turner's syndrome
  - q. Uterine fibroids or adenomyosis

**Authorization will be issued for 12 months**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization



management programs may apply.

**3. Additional Clinical Programs:**

- 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.

**4. Reference:**

N/A

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<b>Change Control</b>	
10/2013	Annual review. No changes to criteria. Added examples of indications other than contraception.
10/2014	Annual review. Increased authorization approval to 60 months.
10/2015	Annual review. Updated format. Added disclaimer to the background section.
10/2016	Updated the authorization to 12 months.
10/2017	Annual review. No changes.
10/2018	Annual review. No changes.
10/2019	Annual review. Added Anovera and information on automated approval language.
10/2020	Annual review. Added Twirla.
11/2021	Annual review. No changes.
11/2022	Annual review. Added state mandate footnote.
11/2023	Annual review. No changes.