



Horizon BCBSNJ
 Medical Necessity Guideline

Section
Policy Number
Effective Date
Review Date

Drugs
 4/25/08
 9/26/08, 11/24/08,
 10/13/09, 11/12/09

BRAND NAME: Crinone

(GENERIC) (progesterone gel)

Prochieve
 (progesterone gel)

Endometrin
 (progesterone vaginal insert)

IMPORTANT NOTE:

*The purpose of this policy is to provide general information applicable to the administration of outpatient prescription drug benefits that Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey, Inc. (collectively "Horizon BCBSNJ") insures or administers. **Outpatient prescription drugs are not covered under all Horizon benefit plans.** If the member's contract benefits differ from the pharmacy guideline, the contract prevails. Although a service, supply drug or procedure may be medically necessary, it may be subject to limitations and/or exclusions under a member's benefit plan. If a service, supply drug or procedure is not covered and the member proceeds to obtain the service, supply drug or procedure, the member may be responsible for the cost. Decisions regarding treatment and treatment plans are the responsibility of the physician. This policy is not intended to direct the course of clinical care a physician provides to a member, and it does not replace a physician's or pharmacist's independent professional clinical judgment or duty to exercise special knowledge and skill in the treatment of Horizon BCBSNJ members. Horizon BCBSNJ is not responsible for, does not provide, and does not hold itself out as a provider of medical care. The physician remains responsible for the quality and type of health care services provided to a Horizon BCBSNJ member.*

Horizon BCBSNJ pharmacy guidelines do not constitute medical advice, authorization, certification, approval, explanation of benefits, offer of coverage, contract or guarantee of payment.

FDA-APPROVED INDICATION

Assisted Reproductive Technology

Progesterone gel 8% is indicated for progesterone supplementation or replacement as part of an Assisted Reproductive Technology (ART) treatment for infertile women with progesterone deficiency.

Secondary Amenorrhea

Progesterone gel 4% is indicated for the treatment of secondary amenorrhea.

Progesterone gel 8% is indicated for use in women who have failed to respond to treatment with progesterone gel 4%.

<u>Criteria for Approval</u>		Yes	No
1.	Is the patient female? [If the answer is no, the no further questions required.]		

2.	Does the patient have a diagnosis of infertility? [If the answer to this question is no, may skip to question 8]	Yes	No
3	Is progesterone prescribed as part of an intrauterine insemination (IUI) procedure in a patient with progesterone deficiency? [If no, then skip to question 5.]	Yes	No
4	Is the patient < 45 years of age? [If yes, then skip to question 8.] [If no, then forward request to Horizon Pharmacy Services at pharmacy_services@horizonblue.com . When approved, go to question 8.]	Yes	No
5	Is progesterone prescribed as part of an ART program [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), tubal embryo transfer (TET), or zygote intrafallopian transfer (ZIFT)] for an infertile woman with progesterone deficiency? [If yes, then forward request to Horizon Pharmacy Services at pharmacy_services@horizonblue.com . When approved, go to question 8.]	Yes	No
6.	Does the patient have a diagnosis of secondary amenorrhea? [If the answer to this question is no, no further questions required]	Yes	No
7.	Is the patient receiving estrogen supplementation for treatment of secondary amenorrhea?	Yes	No
8.	Does the patient have any of the following contraindications to progesterone therapy? <ul style="list-style-type: none"> • Active thrombophlebitis or thrombotic disease, or a history of hormone-associated thrombophlebitis or thromboembolic disorders • Liver dysfunction or liver disease • Known or suspected cancer of the breast or genital organs • Experienced a missed abortion at this time • Undiagnosed vaginal bleeding 	Yes	No

Guidelines for Approval							
Duration of Approval				2 months			
Set 1: IUI < 45 y/o		Set 2: IUI > 45 y/o with Horizon approval		Set 3: ART with Horizon approval		Set 4: Secondary amenorrhea	
Yes to Questions	No to Questions	Yes to Questions	No to Question	Yes to Questions	No to Questions	Yes to Questions	No to Questions
1	8	1	4	1	3	1	2
2		2	8	2	8	6	8
3		3		5		7	
4							

Horizon BCBSNJ Pharmacy Guideline Development Process: This Horizon BCBSNJ Pharmacy Guideline (the “Pharmacy Guideline”) has been developed by Horizon BCBSNJ’s Pharmacy Drug Policy Subcommittee, Clinical Issues Subcommittee, and Quality Improvement Committee which include practicing physicians and pharmacists. This guideline is consistent with generally accepted standards of medical and pharmacy practice, and reflects Horizon BCBSNJ’s view of the subject health care services, supplies drugs or procedures, and in

what circumstances they are deemed to be medically necessary or experimental/ investigational in nature. This Pharmacy Guideline also considers whether and to what degree the subject health care services, supplies or procedures are clinically appropriate, in terms of type, frequency, extent, site and duration and if they are considered effective for the illnesses, injuries or diseases discussed. Where relevant, this Pharmacy Guideline considers whether the subject prescription drugs are being requested primarily for the convenience of the covered person or the health care provider. It may also consider whether the prescription drugs are more costly than alternative prescription drugs that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the relevant illness, injury or disease. In reaching its conclusion regarding what it considers to be the generally accepted standards of medical and pharmacy practice, Horizon BCBSNJ reviews and considers the following: all credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician and health care provider specialty society recommendations, the views of physicians and health care providers practicing in relevant clinical areas (including, but not limited to, the prevailing opinion within the appropriate specialty), the findings and directives of the Food and Drug Administration and any other relevant factor as determined by applicable State and Federal laws and regulations.

RATIONALE

The intent of the criteria is to ensure patients follow selection elements in the labeling as established by Horizon BCBS of New Jersey.

Horizon BCBSNJ has requested that all requests for patients undergoing an ART procedure – either a non-IUI procedure, or IUI and ≥ 45 years or age be sent to Horizon Pharmacy Services to verify whether the patient has coverage for this indication. If the patient qualifies for coverage, Horizon will contact CVS Caremark to proceed with the clinical questions in the criteria. If the patient does not qualify for coverage, Horizon will send a denial letter to the physician and inform CVS Caremark of this decision.

Progesterone gel and inserts are approved for infertile women undergoing an ART procedure who are progesterone deficient. Patients who require progesterone supplementation should receive 90 mg gel once daily or 100mg insert 2-3 times daily, while patients with partial or complete ovarian failure who require progesterone replacement should receive 90 mg gel twice daily or 100mg insert 2-3 times daily. Treatment may begin while undergoing oocyte transfer or within 24 hours of *in vitro* fertilization and continue through day 30 post-transfer. If pregnancy occurs, treatment may be continued until placental autonomy is achieved, up to 10-12 weeks.¹⁻⁴

Progesterone gel is also approved for the treatment of secondary amenorrhea. Causes of secondary amenorrhea include the following: pregnancy, hypothalamic-pituitary causes such as pituitary tumor or stress, hyperandrogenism, uterine causes such as infection or endometriosis, premature ovarian failure, and menopause. Progesterone replacement is primarily utilized in the treatment of symptoms related to menopause and premature ovarian failure. However, information from the Women's Health Initiative suggests that the benefits of hormone therapy do not outweigh the increased risk of breast cancer, heart attack, stroke, and blood clots.¹⁻⁴

Progesterone gel or insert are contraindicated in patients with active thrombophlebitis or thromboembolic disorders, or a history of hormone-associated thrombophlebitis or thromboembolic disorders, liver dysfunction or liver disease. It is also contraindicated in patients with known or suspected malignancy of the breast or genital organs. Progesterone injection is contraindicated in patients with undiagnosed vaginal bleeding. It is also contraindicated in patients who have experienced a missed abortion.¹⁻⁴

REFERENCES

1. Crinone gel 4% and 8% product information. Columbia Laboratories, Inc. December 2006.
2. Prochieve gel 4% and 8% product information. Columbia Laboratories, Inc. November 2004.
3. USPDI. Thomson MICROMEDEX. Greenwood Village, CO. 2007.
4. Kirschstein, R. Current Clinical Issues: Menopausal Hormone Therapy: Summary of a Scientific Workshop. *Annals of Internal Medicine*. www.acponline.org. 2003.
5. MICROMEDEX Healthcare Series Online: Progesterone. Thomson MICROMEDEX 2007.
6. Endometrin vaginal insert product information. Ferring Pharmaceuticals. August 2007.

Pharmacy Guidelines can be highly technical and are designed for use by the Horizon BCBSNJ professional staff in making coverage determinations. Members referring to this policy should discuss it with their treating physician or pharmacist, and should refer to their specific benefit plan for the terms, conditions, limitations and exclusions of their coverage.

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