

Clinical Policy: Non-Formulary and Formulary Contraceptives

Reference Number: HIM.PA.100

Effective Date: 05.01.15

Last Review Date: 05.21

Line of Business: HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

These are general prior authorization criteria for approval of non-formulary and formulary contraceptives.

FDA Approved Indication(s)

Contraceptives are indicated for the prevention of pregnancy.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that non-formulary and formulary contraceptives are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Contraceptive Therapy (must meet all):

1. Request meets one of the following (a or b):
 - a. Prescriber attests that the requested product is medically necessary;
 - b. Request is for product placement on Tier 0.

Approval duration: Duration of request or 12 months, whichever is less

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Contraceptive Therapy (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria.

Approval duration: 12 months

VERY IMPORTANT: Once approval has been entered in the system you must enter exception for copay code (drug needs to pay on Tier 0) and exception for subject to deductible code for the requested drug.

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – HIM.PA.154 for health insurance marketplace or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

Refer to individual prescribing information.

V. Dosage and Administration

Refer to individual prescribing information.

VI. Product Availability

Refer to individual prescribing information.

VII. References

1. United States Department of Labor. Employee Benefits Security Administration: Affordable Care Act Implementation Frequently Asked Questions. Available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs>. Accessed January 14, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Changed guideline to new format. Added section B. for clarification purposes.	05.16	05.16
No clinical changes made to criteria - Converted to new template	01.17	05.17
2Q 2018 annual review: no significant changes.	02.23.18	05.18
2Q 2019 annual review: no significant changes; removed requirement for documentation that continued contraception is required; references reviewed and updated.	01.07.19	05.19

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2020 annual review: no significant changes; references reviewed and updated.	02.12.20	05.20
2Q 2021 annual review: no significant changes; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.14.21	05.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

CLINICAL POLICY

Non-Formulary and Formulary Contraceptives



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