UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Name	2025 P 1022-12
Program	Prior Authorization/Notification
Medication	Contraceptive Medications: medroxyprogesterone acetate (Depo-Provera®), etonogestrel/ethinyl estradiol (NuvaRing®), Oral Contraceptives, norelgestromin/ethinyl estradiol (OrthoEvra®), Annovera® (segesterone/ethinyl estradiol), Twirla® (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, 3/2025
Effective Date	6/1/2025

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[a]:

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

[a] 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

Program	Prior Authorization/Notification - Contraceptive Medications
Change Control	
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 Annovera 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.
3/2025	Annual review. No changes.