**Endocrine Agents: Estrogenic Agents**

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| Criteria 1 | NP Criteria without QL |
| Criteria 2 | Climara (NP, QL), Menostar (NP, QL), Minivelle (NP, QL), Vivelle-Dot (NP, QL) |

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| **Criteria Title** | Endocrine Agents: Estrogenic Agents | | |
| **Criteria Subtitle** | Angeliq, Divigel, Duavee, Elestrin, Estrogel, Estradiol 10 mcg Vag tab, Estradiol/Norethindrone Acetate, Estrogel, Evamist, Femring, Prefest | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ANGELIQ | 059061 | GCNSeqNo |
| ANGELIQ | 069389 | GCNSeqNo |
| DIVIGEL | 031004 | GCNSeqNo |
| DIVIGEL | 060493 | GCNSeqNo |
| DIVIGEL | 062784 | GCNSeqNo |
| DIVIGEL | 079420 | GCNSeqNo |
| DIVIGEL | 080597 | GCNSeqNo |
| DUAVEE | 071889 | GCNSeqNo |
| ELESTRIN | 062699 | GCNSeqNo |
| ESTROGEL | 054628 | GCNSeqNo |
| ESTRADIOL 10 mcg VAG TAB | 078477 | GCNSeqNo |
| ESTRADIOL 10 mcg VAG TAB | 078816 | GCNSeqNo |
| ESTRADIOL 10 mcg VAG TAB | 065966 | GCNSeqNo |
| ESTRADIOL/NORETHINDRONE ACETATE | 040888 | GCNSeqNo |
| ESTRADIOL/NORETHINDRONE ACETATE | 062587 | GCNSeqNo |
| EVAMIST | 062960 | GCNSeqNo |
| FEMRING | 052093 | GCNSeqNo |
| FEMRING | 052094 | GCNSeqNo |
| PREFEST | 044113 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 5999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 6000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 6000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 6001 |
| N | 1235 |
| 3 | 6001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  Please note: Requests for non-preferred drugs must have an inadequate clinical response with preferred drugs with the same delivery method.  If yes, please submit the medication trials and dates. | Y | 6003 |
| N | 6002 |
| 4 | 6002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 6003 |
| N | 1236 |
| 5 | 6003 |  | Select | Is the request for Brand Divigel or generic estradiol gel (generic for Divigel)? | Y | 6004 |
| N | 6006 |
| 6 | 6004 |  | Select | Which product is being requested? | Brand Divigel | 6006 |
| Brand Elestrin | 6006 |
| Brand Estrogel | 6006 |
| Generic estradiol gel (generic for Divigel) | 6005 |
| Other | 1235 |
| 7 | 6005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | 6006 |
| N | 1235 |
| 8 | 6006 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 6007 |
| N | END (Pending Manual Review) |
| 9 | 6007 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Estrogenic Agents | | |
| **Criteria Subtitle** | Climara, Menostar, Minivelle, Vivelle-Dot | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| CLIMARA | 023471 | GCNSeqNo |
| CLIMARA | 023472 | GCNSeqNo |
| CLIMARA | 032174 | GCNSeqNo |
| CLIMARA | 040366 | GCNSeqNo |
| CLIMARA | 052830 | GCNSeqNo |
| CLIMARA | 052831 | GCNSeqNo |
| MENOSTAR | 054714 | GCNSeqNo |
| MINIVELLE | 003202 | GCNSeqNo |
| MINIVELLE | 003203 | GCNSeqNo |
| MINIVELLE | 016767 | GCNSeqNo |
| MINIVELLE | 023270 | GCNSeqNo |
| MINIVELLE | 024555 | GCNSeqNo |
| VIVELLE-DOT | 003202 | GCNSeqNo |
| VIVELLE-DOT | 003203 | GCNSeqNo |
| VIVELLE-DOT | 016767 | GCNSeqNo |
| VIVELLE-DOT | 023270 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 5999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 6000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 6000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 6001 |
| N | 1235 |
| 3 | 6001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  Please note: Requests for non-preferred drugs must have an inadequate clinical response with preferred drugs with the same delivery method.  If yes, please submit the medication trials and dates. | Y | 6003 |
| N | 6002 |
| 4 | 6002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 6003 |
| N | 1236 |
| 5 | 6003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 6004 |
| N | END (Pending Manual Review) |
| 6 | 6004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| --- | --- |
| **Last Approved** | 5/16/2023 |
| **Other** |  |