CVS/caremark™

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS **VAGINAL PROGESTONE GEL**

BRAND NAME **CRINONE**
(generic) **(progesterone vaginal gel)**

Endometrin
(progesterone vaginal gel)

Prochieve
(progesterone vaginal gel)

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C8912-A***

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for a non-infertility indication? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being used in conjunction with any type of Artificial Reproductive Technology (ART) procedure [e.g., in Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or Intrauterine or Artificial Insemination]?	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Approve, 12 months	Go to 2
2.	Deny	Approve, 12 months

REFERENCES

1. NCSHP Prior Authorization Approval Policy.

Written by: UM Development (NB)
Date Written: 05/2016
Revised:
Reviewed: Medical Affairs: (ME) 06/2016

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name