UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 2220-8
Program	Prior Authorization – Medical Necessity
Medication	Phexxi®/Phexx® (lactic acid, citric acid, and potassium bitartrate) vaginal gel
P&T Approval Date	10/2020, 3/2021, 5/2021, 5/2022, 5/2023, 5/2024, 5/2025, 5/2026
Effective Date	8/1/2026

1. Background:

Phexxi/Phexx (lactic acid, citric acid, and potassium bitartrate) vaginal gel is indicated for the prevention of pregnancy in females of reproductive potential for use as an on-demand method of contraception. Phexxi/Phexx is not effective for the prevention of pregnancy when administered after intercourse.

2. Coverage Criteria[a]:

A. Authorization

1. **Phexxi/Phexx** will be approved based on **all** of the following criteria:

   a. Used for the prevention of pregnancy

   -AND-

   b. Patient is unable to use other methods of contraception due to failure, contraindication, intolerance or refusal. Examples include:

      1) Injection (e.g., Depo-Provera)
      2) Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz]
      3) Transdermal Patch (e.g. Twirla, Xulane)
      4) Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing)
      5) Diaphragm
      6) Sponge (e.g. Today)
      7) Cervical Cap (e.g., FemCap)
      8) Female Condom

   -AND-

   c. History of failure, contraindication, or intolerance to nonoxynol-9 based spermicide

   -AND-

   d. Provider attests they have counseled the patient regarding a higher rate of pregnancy prevention with the use of other methods of contraception (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi/Phexx

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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. References:

1. Phexxi [package insert]. San Diego, CA: Evofem, Inc; June 2023.

Program	Prior Authorization – Medical Necessity Phexxi/Phexx
Change Control	
10/2020	New program.
3/2021	Modified provider attestation statement.
5/2021	Modified provider attestation statement.
5/2022	Annual review. Updated references.
5/2023	Annual review. Updated methods of contraception to examples a member is unable to use.
5/2024	Annual review. Updated references.
5/2025	Annual review. No changes.
5/2026	Annual review. Added the product Phexx to the criteria.

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