UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2185-6
Program	Prior Authorization – Medical Necessity
Medication	Slynd® (drospirenone)
P&T Approval Date	1/2020, 7/2020, 4/2021, 1/2022, 2/2023, 2/2024
Effective Date	5/1/2024

1. **Background:**
Oral contraceptives are available as either combination estrogen/progesterone-containing contraceptives or as progesterone-only contraceptives. Progesterone-only contraceptives should be used when estrogen-containing contraceptives are contraindicated. Slynd (drospirenone) is a progesterone-only contraceptive indicated for use by females of reproductive potential to prevent pregnancy.

2. **Coverage Criteria[a]:**

A. Initial Authorization

1. **Slynd** will be approved based on **all** of the following criteria:

a. Used for the prevention of pregnancy

-AND-

b. Use of estrogen-containing contraceptives is contraindicated (e.g., breast feeding, comorbidities/health conditions)

-AND-

c. History of failure, contraindication, or intolerance to a progesterone-only contraceptive [e.g., norethindrone (generic Ortho Micronor®)]

-AND-

d. Prescriber attests the benefits of drospirenone-containing, progestin-only contraceptives outweigh the potential risk of venous thromboembolism.

Authorization will be issued for 12 months.

B. Reauthorization

1. **Slynd** will be approved based on **all** of the following criteria:

a. Documentation of positive clinical response to Slynd therapy

-AND-

b. Use of estrogen-containing contraceptives is contraindicated (e.g., breast feeding, comorbidities/health conditions)

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. Slynd [package insert]. Florham Park, NJ: Exeltis USA, Inc; May 2019.
2. Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. *MMWR Recomm Rep* 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1

Program	Prior Authorization – Medical Necessity
Change Control	
1/2020	New program.
7/2020	Updated contraindications to include history of breast cancer and migraine with aura.
4/2021	Simplified contraindication language and added documentation of contraindication.
1/2022	Annual review. No changes.
2/2023	Annual review. No changes.
2/2024	Annual review. Updated criteria to note a progesterone-only contraceptive due to the approval of the over-the-counter contraceptive.