UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2185-7
Program	Prior Authorization – Medical Necessity
Medication	Slynd® (drospirenone)
P&T Approval Date	1/2020, 7/2020, 4/2021, 1/2022, 2/2023, 2/2024, 9/2024
Effective Date	11/17/2024

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. Authorization

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

   a. Used for the prevention of pregnancy

   -AND-

   b. History of failure, contraindication, or intolerance to both of the following progesterone-only contraceptives

      1) norethindrone (generic Ortho Micronor®)
      2) norgestrel (Opill)

   -AND-

   c. Provider attests that patient has been instructed to avoid estrogen containing contraceptives due to a health concern or the patient is currently breastfeeding

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.

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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.
9/2024	Require failure of two progestin only contraceptives, removed estrogen failure and updated prescriber attestation statement. Reauthorization removed.

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