Pharmacy Medical Necessity Guidelines: Intrarosa® (prasterone)

Effective: January 12, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Intrarosa® (prasterone) vaginal insert is a steroid indicated for the treatment of moderate to severe dyspareunia (a symptom of vulvar and vaginal atrophy) due to menopause. Intrarosa® is available as 6.5 mg tablets. Patients should insert one Intrarosa® vaginal insert once daily at bedtime using the applicator.

Intrarosa® is contraindicated in undiagnosed abnormal genital bleeding. Any postmenopausal woman with undiagnosed persistent or recurring genital bleeding should be evaluated to determine the cause of the bleeding before consideration of treatment with Intrarosa®.

Estrogen is a metabolite of prasterone. Use of exogenous estrogen is contraindicated in women with a known or suspected history of breast cancer. Intrarosa® has not been studied in women with a history of breast cancer.

COVERAGE GUIDELINES

The plan may authorize coverage of Intrarosa® for Members when **all** the following criteria are met and limitations do not apply:

1. The Member has a diagnosis of dyspareunia due to menopause

AND

2. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of treatment with at least two alternative agents

LIMITATIONS

1. The coverage of Intrarosa® is limited to 1 box (28 inserts) per 28 days.

CODES

None

REFERENCES

1. Intrarosa (prasterone) [package insert]. Waltham, MA: AMAG Pharmaceuticals Inc; February 2018.

APPROVAL HISTORY

January 9, 2018: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. January 8, 2019: Administrative changes made to template.
2. January 14, 2020: No changes.
3. January 12, 2021: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.