Pharmacy Medical Necessity Guidelines
Makena® (hydroxyprogesterone caproate)

Effective: 8/27/14

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<th>Clinical Documentation and Prior Authorization Required</th>
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OVERVIEW

FDA-APPROVED INDICATIONS
Makena is a progestin indicated to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. The effectiveness of Makena is based on improvement in the proportion of women who delivered < 37 weeks of gestation. There are no controlled trials demonstrating a direct clinical benefit, such as improvement in neonatal mortality and morbidity.

Limitation of use: While there are many risk factors for preterm birth, safety and efficacy of Makena has been demonstrated only in women with a prior spontaneous singleton preterm birth. It is not intended for use in women with multiple gestations or other risk factors for preterm birth.

Preterm birth is defined as a live birth before 37 completed weeks of gestation. Additional classifications include late preterm (34 to 36 weeks), moderately preterm (32 to 36 weeks) and very preterm (< 32 weeks). In the U.S., preterm birth affects approximately 12%, or 480,000 births, and about 13 million births globally. Preterm birth has increased 27% over the last decade in the U.S., accounting for 85% of all perinatal morbidity and mortality.

Risk factors for preterm delivery include a history of preterm delivery, maternal weight less than 50 kg, African American race, bleeding, sexually transmitted infection during the pregnancy, and multiple gestation. Preterm labor is considered to be a multifactorial process and varies according to gestational age, genetic, and environmental factors. There are several commonly recognized pathways and etiologies leading to spontaneous preterm birth. Although these pathways may cause preterm birth at any point in gestation, certain pathways are more predominant at a specific gestational age.

Few interventions have moderate- to high-quality evidence for reducing preterm birth. Two interventions, progesterone and smoking cessation, are supported by high quality of evidence and are strongly recommended to prevent preterm births, especially in low- and middle-income countries. For more than forty years, 17-alpha hydroxyprogesterone caproate has been used for prevention of preterm labor, although it was never FDA-approved for this indication. In normal pregnancy, progesterone may suppress immunity to prevent rejection of fetal cells and may induce myometrial quiescence. The ACOG and the Society for Maternal Fetal Medicine acknowledge the benefits of progesterone for preterm birth, although the ideal progesterone formulation is unknown. Makena (hydroxyprogesterone caproate) is the only FDA-approved therapy for the prevention of recurrent preterm labor.

PHARMACY COVERAGE GUIDELINES

Tufts Health Plan – Network Health may authorize coverage of Makena (hydroxyprogesterone caproate) for members when all of the following criteria are met and limitations do not apply:

- The member has a documented history of a singleton spontaneous preterm birth (prior to 37 weeks gestation) AND
- The member is pregnant with a single fetus AND
- The prescribing physician is an OB-GYN specialist.

LIMITATIONS

1. Treatment should begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Treatment must end before week 37 (through 36 weeks, 6 days).
2. Coverage is limited to a maximum total of 20 doses (16 weeks gestation to 36 weeks gestation).
3. Makena (hydroxyprogesterone caproate) will not be approved for the following indications as it is considered experimental and investigational and of unproven medical efficacy:
   - Prevention of spontaneous preterm birth in women with:
     - Short cervix with or without cerclage and no prior preterm birth
     - Current multi-fetal pregnancy (twins or greater)
     - Previous medically indicated preterm birth
   - Initiation of Makena (hydroxyprogesterone caproate) after 26 weeks, 6 days of gestation

REFERENCES


APPROVAL HISTORY

- 8/12/14: Reviewed by the Pharmacy and Therapeutics Committee
- 4/14/11: Reviewed by the Pharmacy and Therapeutics Committee
clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

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.