Clinical Policy: Hydroxyprogesterone Caproate (Makena/compound)

Reference Number: CP.PHAR.14
Effective Date: 08/06
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® medical policy for hydroxyprogesterone caproate intramuscular injection (Makena®/compound).

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that hydroxyprogesterone caproate is **medically necessary** for members meeting the following criteria:

A. Prevention of preterm birth (meets all):
1. Current singleton pregnancy;
2. History of singleton spontaneous preterm birth (delivery at < 37 weeks of gestation following spontaneous preterm labor or premature rupture of membranes);
3. Therapy to begin between 16 weeks, 0 days and 27 weeks, 6 days of gestation;
4. Request is for Makena unless there is a contraindication or documented reason to use an alternative formulation;
5. Prescribed dose does not exceed 250mg (1ml), once weekly (every 7 days);
6. Member has none of the following contraindications:
   a. Current or history of thrombosis or thromboembolic disorder;
   b. Known or suspected breast cancer, other hormone-sensitive cancer, or history of these conditions;
   c. Undiagnosed abnormal vaginal bleeding unrelated to pregnancy;
   d. Cholestatic jaundice of pregnancy;
   e. Liver tumor, benign or malignant, or active liver disease;
   f. Uncontrolled hypertension.

Approval duration: Up to a total of 21 doses to reach week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first.

Background

Description/Mechanism of Action:
Hydroxyprogesterone caproate is a synthetic progestin. The mechanism by which hydroxyprogesterone caproate reduces the risk of recurrent preterm birth is not known.

Formulations:
Makena is supplied as
- 1 mL of a sterile solution in a single dose glass vial.

- Each 1 mL vial contains hydroxyprogesterone caproate USP, 250 mg/mL (25% w/v), in castor oil USP (30.6% v/v) and benzyl benzoate USP (46% v/v).
- Single unit carton: Contains one 1 mL single dose vial of Makena containing 250 mg of hydroxyprogesterone caproate.

- 5 mL of a sterile solution in a multidose glass vial.
  - Each 5 mL vial contains hydroxyprogesterone caproate USP, 250 mg/mL (25% w/v), in castor oil USP (28.6% v/v) and benzyl benzoate USP (46% v/v).
    - Includes the preservative benzyl alcohol NF (2% v/v).
  - Single unit carton: Contains one 5 mL multidose vial of Makena (250 mg/mL) containing 1250 mg of hydroxyprogesterone caproate.

FDA Approved Indications:
Makena is a progestin/intramuscular formulation 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.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1725	Injection, hydroxyprogesterone caproate, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Converted criteria to algorithm table	07/13	10/13
Added multiple gestation question to algorithm	12/13	01/14
Renamed to Makena Changed references in policy from 17P to Makena Added FDA approved indications and contraindications Updated background information Added safety information Updated references to include additional information section Updated algorithm to include only Makena	01/15	01/15
Policy converted to new template.	12/15	01/16

Reviews, Revisions, and Approvals	Date	Approval Date
Criteria: age requirement added; criteria added asking for dose, frequency; question regarding major fetal anomalies detected by ultrasound removed		
Added language to prefer Makena formulation Allowed start of therapy up to 27 wks 6 days and continuation through 36 wk 6 days Removed age limit	04/16	05/16
No criteria changes. Added compound to the title. Background section reformatted.	03/17	04/17

References

1. Makena prescribing information. Waltham, MA: AMAG Pharmaceuticals, Inc.; April 2016. Available at http://www.makena.com/pdf/makena_pi.pdf. Accessed March 2, 2017.
2. Clinical management guidelines for obstetrician-gynecologists – practice bulletin 130: prediction and prevention of preterm birth. The American College of Obstetricians and Gynecologists. Obstet Gynecol. October 2012; 120(4): 964-973.
3. Mason MV, Poole-Yaeger A, Lucas B, Krueger C, et al. Effects of a pregnancy management program on birth outcomes in managed Medicaid. Manag Care. April 2011; 20(4): 39-46.
4. Mason MV, Poole-Yaeger A, Krueger C, et al. Impact of 17P usage on NICU admissions in a managed Medicaid population – a five-year review. Manag Care. February 2010; 19(2): 46-52.
5. Romero R, Stanczyk FZ. Progesterone is not the same as 17α-hydroxyprogesterone caproate: implications for obstetrical practice. Am J Obstet Gynecol. June 2013; 208(6): 421-426.

Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective

date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.