Field Name	Field Description
Prior Authorization Group Description	**Hydroxyprogesterone caproate (generic Delalutin)**
Drugs	Hydroxyprogesterone caproate (generic Delalutin)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Pregnancy
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber must be a gynecologist or in consultation with a gynecologist
Coverage Duration	If all the criteria are met, the initial request will be approved for up to 6 months. For continuation of therapy, the request will be approved for up to 6 months.

Other Criteria
 	
Date: 4/2025
	<u>Initial Authorization:</u>
	• Medication is prescribed at an FDA approved dose
	• If request is for preterm birth, do not approve
	• Request is for one of the following indications:
	  o Amenorrhea or abnormal uterine bleeding due to hormonal imbalance
	  o Production of secretory endometrium and desquamation
	  o Test for endogenous estrogen production
	  o Advanced uterine adenocarcinoma
	
	<u>Re-Authorization:</u>
	• Documentation or provider attestation of clinical benefit
	• Medication is prescribed at an FDA approved dose
	
	If all the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.