

## **Clinical Policy: Prasterone (Intrarosa)**

Reference Number: CP.PMN.99

Effective Date: 12.20.16

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Prasterone (Intrarosa<sup>®</sup>) is an inactive endogenous steroid and is converted into active androgens and/or estrogens.

### **FDA Approved Indication(s)**

Intrarosa is indicated for the treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy, due to menopause.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Intrarosa is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Dyspareunia (must meet all):**

1. Diagnosis of dyspareunia due to menopause;
2. Age  $\geq$  18 years;
3. Failure of two vaginal lubricants or vaginal moisturizers, unless clinically significant adverse effects are experienced or all are contraindicated (*see Appendix B*);\*  
*\*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
4. Failure of  $\geq$  4 week trial of one vaginal estrogen (e.g., estradiol vaginal cream (Estrace<sup>®</sup>), estradiol vaginal insert (Vagifem<sup>®</sup>), Premarin<sup>®</sup> vaginal cream), unless clinically significant adverse effects are experienced or all are contraindicated (*see Appendix B*);\*  
*\*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Dose does not exceed one vaginal insert daily.

##### **Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

##### **B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

**CLINICAL POLICY****Prasterone**

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy****A. Dyspareunia (must meet all):**

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy (e.g., dyspareunia symptom reduction);
3. If request is for a dose increase, new dose does not exceed one vaginal insert daily.

**Approval duration:****Medicaid/HIM** – 12 months**Commercial** – 12 months or duration of request, whichever is less**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**CLINICAL POLICY**

**Prasterone**

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
estradiol vaginal cream (Estrace®)	Initial: 2 to 4 gm vaginally QD for 1 to 2 weeks, gradually reduce to 50% of initial dose for 1 to 2 weeks Maintenance: 1 gm 1 to 3 times a week	Varies
Premarin® (conjugated estrogens) vaginal cream	0.5 gm intravaginally twice per week continuously	Varies
estradiol vaginal insert (Vagifem®)	1 insert intravaginally daily for 2 weeks, followed by 1 insert twice weekly	1 insert/day
Vaginal Lubricants: <i>Water-based</i> Astroglide, FemGlide, Just Like Me, K-Y Jelly, Pre-Seed, Slippery Stuff, Summer’s Eve <i>Silicone-based</i> ID Millennium, Pink, Pjur, Pure Pleasure	Apply intravaginally before sex	Varies
Vaginal moisturizers: Fresh Start, K-Y Silk-E, Moist Again, Replens, K-Y Liquibeads	Apply intravaginally before sex	Varies

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): undiagnosed abnormal genital bleeding
- Boxed warning(s): none reported

**CLINICAL POLICY**

**Prasterone**

**V. Dosage and Administration**

Drug Name	Dosing Regimen	Maximum Dose
Dyspareunia due to menopause	Administer one vaginal insert once daily at bedtime, using the provided applicator	1 insert/day

**VI. Product Availability**

Vaginal insert: 6.5 mg

**VII. References**

1. Intrarosa Prescribing Information. Quebec City, Canada: Endoceutics Inc., November 2020. Available at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ada639d4-bac0-2ad0-e053-2a95a90afce7>. Accessed October 21, 2025.
2. American College of Obstetricians and Gynecologists Committee on Practice Bulletins-Gynecology. ACOG Practice Bulletin No. 213: Female sexual dysfunction. *Obstet Gynecol.* 2019;134(1):e1-e18.
3. Management of symptomatic vulvovaginal atrophy: 2013 position statement of The North American Menopause Society. *Menopause.* 2013;20:888-902.
4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed October 10, 2022.
5. North American Menopause Society (NAMS) Position Statement: The 2020 genitourinary syndrome of menopause position statement of The NAMS. *Menopause: The Journal of The North American Menopause Society.* 2020: 27(9); 976-92.
6. Christmas M, Huguenin A, Iyer S. Clinical Practice Guidelines for Managing Genitourinary Symptoms Associated With Menopause. *Clin Obstet Gynecol.* 2024 Mar 1;67(1):101-114.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; revised Commercial approval duration from “Length of Benefit” to “12 months or duration of request, whichever is less”; added Appendix C; references reviewed and updated.	11.11.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.10.22	
1Q 2023 annual review: no significant changes; modified redirection language per template to state “clinically significant adverse effects are experienced or all are contraindicated”; references reviewed and updated.	10.11.22	02.23
1Q 2024 annual review: no significant changes; references reviewed and updated.	10.23.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	10.22.24	02.25
Added step therapy bypass for IL HIM per IL HB 5395.	09.16.25	

**CLINICAL POLICY**

**Prasterone**

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2026 annual review: no significant changes; references reviewed and updated.	10.21.25	02.26

**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.

**CLINICAL POLICY****Prasterone**

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.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene<sup>®</sup> and Centene Corporation<sup>®</sup> are registered trademarks exclusively owned by Centene Corporation.