

Clinical Policy: Estradiol Vaginal Ring (Femring)

Reference Number: CP.PMN.263

Effective Date: 01.01.22

Last Review Date: 11.21

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Estradiol vaginal ring (Femring[®]) is an estrogen steroid.

FDA Approved Indication(s)

Femring is indicated for the treatment of moderate to severe vasomotor symptoms due to menopause and moderate to severe 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[®] that Femring is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Dyspareunia (must meet all):

1. Diagnosis of dyspareunia (vulvar and vaginal atrophy) or vasomotor symptoms due to menopause;
2. Age \geq 18 years;
3. Failure of two vaginal lubricants or vaginal moisturizers, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
4. Failure of \geq 4 week trial of one vaginal estrogen (e.g., estradiol vaginal cream (Estrace[®]), estradiol vaginal insert (Vagifem[®]), Premarin[®] vaginal cream), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
5. Dose does not exceed one vaginal ring every 3 months.

Approval duration:

Medicaid/HIM – 12 months

Commercial - Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

CLINICAL POLICY
Estradiol Vaginal Ring

II. Continued Therapy

A. Dyspareunia (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
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 ring every 3 months.

Approval duration:

Medicaid/HIM – 12 months

Commercial - Length of Benefit

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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.

Drug	Dosing Regimen	Dose Limit/ Maximum Dose
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

CLINICAL POLICY
Estradiol Vaginal Ring

Drug	Dosing Regimen	Dose Limit/ Maximum Dose
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; known, suspected, or history of breast cancer; known or suspected estrogen-dependent neoplasia; active DVT, PE, or history of these conditions; active arterial thromboembolic disease (for example, stroke and MI), or a history of these conditions; known anaphylactic reaction or angioedema to Femring; known liver impairment or disease; known protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders; known or suspected pregnancy
- Boxed warning(s): endometrial cancer, cardiovascular disorders, breast cancer, and probable dementia

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Dyspareunia/ vasomotor symptoms due to menopause	Administer one vaginal ring every 3 months	1 vaginal ring/3 months

VI. Product Availability

Vaginal ring: 12.4 mg, 24.8 mg

VII. References

1. Femring Prescribing Information. Irvine, CA: Allergan USA, Inc., August 2017. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021367s014s015lbl.pdf. Accessed April 1, 2021.

CLINICAL POLICY
Estradiol Vaginal Ring

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. Clinical Care Recommendations, Chapter 3: Clinical Issues. The North American Menopause Society. Available at: <http://www.menopause.org/publications/clinical-care-recommendations/chapter-3-clinical-issues>. Accessed April 1, 202.
5. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 1, 202.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created per March SDC and prior clinical guidance.	03.26.21	11.21

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.

CLINICAL POLICY

Estradiol Vaginal Ring

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.

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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.

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