



## Drug Coverage Policy

Effective Date ..... 5/1/2026

Coverage Policy Number .....IP0035

Policy Title.....Prenatal Vitamins

# Prenatal Vitamins

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### **INSTRUCTIONS FOR USE**

*The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.*

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### **OVERVIEW**

**Preventive care services are covered as required by the Affordable Care Act (ACA). The ACA designated resources that identify preventive services required for coverage are:<sup>1</sup>**

- United States Preventive Services Task Force (USPSTF) grade A or B recommendations
  - The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400-800 µg) of folic acid (A recommendation)<sup>2</sup>
- Advisory Committee on Immunization Practices (ACIP) recommendations adopted by the Director of the Center for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA)

The ACA states reasonable medical management techniques may be used to determine coverage limitations if a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service. Reasonable medical management techniques may include precertification, concurrent review, claim review, or similar practices to determine coverage limitations under the plan. These established reasonable medical management techniques and practices may be utilized to determine frequency, method, treatment or setting for the provision of a recommended preventive service. <sup>1</sup>

## Coverage Policy

### POLICY STATEMENT

Prior Authorization is required for benefit coverage of Prenatal Vitamins. All approvals are provided for the duration noted below.

#### Employer Plans and Individual and Family Plans:

Non-Covered Product	Criteria
<p><b>Non-Patient Protection and Affordable Care Act (PPACA) Prenatal Vitamin Supplements</b> (i.e., folic acid requirements &lt; 0.4 mg or &gt; 0.8 mg)</p> <p>For example, AZeschew, Azesco, DermacinRx Prenatrix, DermacinRx, Gestyra, Natal PNV, PNV Tab, Pregen DHA, Pregenna, Prenatal Vitamin Preparations (generic for NEO-VITAL RX), Trinaz, Zalvit, Ziphex.</p>	<p>Approve for 1 year if the patient meets <b>ONE</b> of the following:</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> generic prenatal vitamin formulation (for example, Prenatal Plus, Prenatal Vitamin + Low Iron, Prenatal-19, Vitafol).</li> <li>2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.</li> </ol>

Receipt of sample product does not satisfy any criteria requirements for coverage.

### Conditions Not Covered

Prenatal Vitamins are considered not medically necessary. Criteria will be updated as new published data are available.

## References

1. Health and Human Services. Center for Consumer Information and Insurance Oversight. Affordable Care Act Implementation. FAQs-Set 12. Accessed January 31, 2025. Available at: [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs12.html](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html).

2. United States Preventive Services Task Force. USPSTF A and B Recommendations. Accessed June 21, 2023. Available at: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication>.

## Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	<b>Updated from</b> "There is documentation the individual has had an inadequate response, contraindication, or is intolerant to FIVE covered prescription prenatal vitamins" <b>to</b> "Approve for 1 year if patient meets <b>ONE</b> of the following: Patient has tried <b>ONE</b> generic prenatal vitamin formulation (for example, Prenatal Plus, Prenatal Vitamin + Low Iron, Prenate Mini, Prenatal-19, Vitafol); Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins." <b>Added</b> Individual and Family Plan to table	5/1/2025
Selected Revision	<b>Updated</b> key words in properties of coverage policy document.	11/1/2025
Selected Revision	<b>Updated</b> key words in properties of coverage policy document.	1/15/2026
Annual Revision	<b>No criteria changes.</b>  <b>Employer Plans and Individual and Family Plans:</b> <b>Added</b> (keywords updated) Gestyra tablets to policy.	5/1/2026

The policy effective date is in force until updated or retired.

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