I. Medication Description

Gonadotropin Releasing Hormone (GnRH) agonists act as potent inhibitor of gonadotropin secretion, initially increasing FSH and LH secretion resulting in transient increases in estrogen in females and testosterone levels in males. Long-term therapy suppresses gonadotropin release from the pituitary gland and reduces steroidogenesis in the ovaries and testicles.

II. Position Statement

- Coverage is provided immediately, without a prior authorization review, for Lupron Depot for the following ICD 10 code: C61 (prostate cancer)
- Coverage is determined through a prior authorization process with supporting clinical documentation for all other requests.

III. Policy

Coverage for Eligard, Lupron Depot, leuprolide injection, Lutrate Depot, and Trelstar for oncology indications is available when the following criteria have been met:

- The medication is prescribed by a hematologist/oncologist AND
- The requested use is otherwise supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

Coverage for Lupron Depot/Lupron Depot Ped is also provided for treatment of the following conditions:

- Central Precocious Puberty (idiopathic or neurogenic):
  - Coverage is requested by an endocrinologist AND
  - Patient is less than 11 years old for females or 12 years old for males OR
  - If age is greater than the above, clear medical necessity of further treatment must be outlined with physician statement and supported by patient chart/progress notes.
- Endometriosis
- For the preoperative treatment of anemia due to uterine leiomyomata (fibroids).
- Gender dysphoria
The diagnosis of gender dysphoria and the referral for hormone therapy have been made by a mental health professional in accordance with the WPATH criteria AND
The patient must be followed by an endocrinologist AND
If used for suppression of puberty, therapy should not be started earlier than Tanner stage 2.

Coverage for Lupaneta is provided for the treatment of endometriosis.

Coverage for leuprolide injection is also provided for the treatment of the following conditions:
- Central precocious puberty (idiopathic or neurogenic):
  - Treatment is requested by an endocrinologist AND
  - Patient is less than 11 years old for females or 12 years old for males OR
  - If age is greater than the above, clear medical necessity of further treatment must be outlined with physician statement and supported by patient chart/progress notes.
- Stimulation testing for central precocious puberty (idiopathic or neurogenic)

Coverage for Fensolvi is provided for treatment of:
- Central Precocious Puberty:
  - Coverage is requested by an endocrinologist AND
  - Patient is less than 11 years old for females or 12 years old for males OR
  - If age is greater than the above, clear medical necessity of further treatment must be outlined with physician statement and supported by patient chart/progress notes.

Coverage for Synarel is provided for the treatment of the following conditions:
- Central precocious puberty (idiopathic or neurogenic):
  - Treatment is requested by an endocrinologist AND
  - Patient is less than 11 years old for females or 12 years old for males OR
  - If age is greater than the above, clear medical necessity of further treatment must be outlined with physician statement and supported by patient chart/progress notes.
- Endometriosis

Coverage for Triptodur is provided for treatment of:
- Central Precocious Puberty:
  - Coverage is requested by an endocrinologist AND
  - Patient is less than 11 years old for females or 12 years old for males OR
  - If age is greater than the above, clear medical necessity of further treatment must be outlined with physician statement and supported by patient chart/progress notes.

IV. Quantity Limitations

- Eligard: 45mg every 6 months
- Lupron Depot/Lupron Depot Ped:
  - Prostate cancer: up to total of 90mg per 12 months
  - Central precocious puberty: 15mg every month (180mg every 12 months)
Drug Therapy Guidelines

Gonadotropin-Releasing Hormone Agonists

Last Review Date: 6/2020

- All other indications: 11.25mg every 3 months (22.5mg every 6 months)
- Lupron/leuprolide: to allow for desired response within FDA-dosing guidelines
- Lupaneta:
  - leuprolide: 11.25mg every 3 months
  - norethindrone 5mg tablets: 90 every 3 months
- Lutrate Depot: 22.5mg every 3 months
- Triptodur: 22.5mg every 6 months
- Trelstar: 22.5mg every 6 months
- Fensolvi: 45mg every 6 months
- Synarel: 1800mcg/day

V. Coverage Duration

Coverage will be provided as follows:
- Prostate cancer: 12 months and may be renewed
- Central Precocious Puberty: 12 months and may be renewed
  - Until female patient reaches 11 years of age
  - Until male patient reaches 12 years of age
- Endometriosis, Breast Cancer, Ovarian Cancer: 6 months and may be renewed
- Uterine Fibroids: 3 months and may be renewed
- Gender dysphoria: 12 months and may be renewed
- Stimulation testing for central precocious puberty: a 1 month authorization for 1 dose will be provided and may not be renewed

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:
- Prostate Cancer:
  - Member is continuing prostate cancer treatment with adequate clinical response AND
  - Absence of unacceptable toxicity from the drug
- Breast Cancer, Ovarian Cancer:
  - Tumor response with stabilization of disease or decrease in size of tumor or tumor spread AND
  - Absence of unacceptable toxicity from the drug
- Central Precocious Puberty:
  - Absence of unacceptable toxicity from the drug AND
  - One of the following is true:
    - Patient’s age is less than 11 years for females and 12 years for males OR
    - If age is greater than the above, clear medical necessity of further treatment is outlined with physician statement and supported by patient chart/progress notes
- Stimulation testing for central precocious puberty: n/a
- Uterine fibroids/Endometriosis:
  - Renewal is dependent on recurrence of symptoms AND
There is an absence of unacceptable toxicity from the drug AND

- Documentation of why member cannot undergo surgical intervention is provided AND
- If used longer than 12 months, appropriate periodic bone mineral density assessment is ensured.

- Gender dysphoria:
  - Absence of unacceptable toxicity from the drug AND
  - Chart notes assessing pubertal development, height, weight, BMI, bone age, bone mineral density AND
  - Physician statement outlining medical necessity and treatment plan.

VII. Billing/Coding Information

- Eligard
  - Available as 7.5mg, 22.5mg, 30mg, and 45mg suspension
  - J9217 - 1 billable unit equals 7.5mg
  - Available as a medical benefit

- Lupron Depot/Lupron Depot Ped
  - Available as 3.75mg, 7.5mg, 11.25mg, 15mg, 22.5mg, 30mg, 45mg powder for suspension
  - J1950 - 1 billable unit equals 3.75 mg
  - J9217 – 1 billable unit equals 7.5 mg
  - Available as a medical benefit

- Leuprolide injection
  - Available as 1mg/0.2ml solution
  - J9218 - 1 billable unit equals 1 mg
  - Available as a medical benefit and a pharmacy benefit

- Lupaneta
  - Available as a 1-month kit containing 3.75mg leuprolide acetate for suspension with 30 count bottle of 5mg norethindrone oral tablets and 3-month kit containing 11.25mg leuprolide acetate for suspension with 90 count bottle of 5mg norethindone oral tablets
  - J3490
  - Available as a medical benefit

- Lutrate Depot
  - Available as 22.5mg single dose vials as a kit with a prefilled syringe containing diluent and a MIXJECT transfer device
  - J3490
  - Available as a medical benefit

- Synarel
  - Available as 8ml bottle containing a 2mg/ml nasal solution

- Triptodur
  - Available as 22.5mg triptorelin as a powder cake for reconstitution with the co-packaged 2ml of diluent SWFI
  - C9016: 1 billable unit equals 3.75 mg
  - Available as medical benefit

- Trelstar
Available as 3.75mg, 11.25 mg, and 22.5mg as a single dose vial containing sterile lyophilized microgranules with the co-packaged 2ml of diluent SWFI

Available as a medical benefit

- **Fensolvi**
  - Available as a 45 mg single dose vial in a kit with a prefilled syringe containing diluent for reconstitution
  - J1950: 1 billable unit equals 3.75 mg
  - Available as a medical benefit

- Pertinent diagnoses:
  - Breast cancer: C50.019, C50.029, C50.119, C50.219, C50.319, C50.419, C50.519, C50.619, C50.819, C50.919, C50.929, Z85.3
  - Central Precocious Puberty: E30.1, E30.8
  - Endometriosis: N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9
  - Ovarian Cancer: C48.1, C48.2, C48.8, C56.1, C56.2 C56.9, C57.00-C57.02, C57.10-C57.12, C57.20-C57.22, C57.3, C57.4, C57.7-C57.9, Z85.43
  - Prostate Cancer: C61, Z85.46
  - Uterine Fibroids: D25.0, D25.1, D25.2, D25.9
  - Gender identity disorder: F64.1, F64.2

### VIII. Summary of Policy Changes

- **1/1/12**
  - Requirement of iron usage timeframes added for anemia secondary to uterine leiomyomata
  - Quantity allowances and coverage duration revised
  - Removal of diagnosis 198.82 from autopay, will be reviewed
  - Central precocious puberty (259.1) no longer autopay diagnosis, will be reviewed
    - Coverage criteria outlined
    - Renewal criteria outlined
  - Clarification of pharmacy benefit vs. medical benefit made
  - Coverage criteria for breast and ovarian cancers included

- **12/15/12**
  - Removal of trial of iron supplementation required for fibroid treatment
  - Addition of monitoring for bone density to warnings
  - Addition of renewal criteria for uterine fibroids/endometriosis to address surgical intervention

- **6/2013:** added Lupaneta to policy

- **12/15/13:**
  - Change in criteria for ovarian cancer and uterine fibroids
  - Clarified Lupron Depot is not covered under the pharmacy benefit

- **1/1/15:**
  - Updated breast cancer coverage criteria to mirror current NCCN treatment guidelines
  - Added quantity limits to Lupaneta
IX. References

7. Product Information: Eligard® (leuprolide), revised 04/2019
<table>
<thead>
<tr>
<th>Drug Therapy Guidelines</th>
<th>Gonadotropin-Releasing Hormone Agonists</th>
<th>Last Review Date: 6/2020</th>
</tr>
</thead>
</table>

15. Prescribing Information: Triptodur. Arbor Pharmaceuticals, LLC, Atlanta, GA. Revised 10/2018
16. Prescribing Information: Trelstar. Allergan USA, Inc. Irvine, CA 92612. Revised 12/2018

*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment audits. The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.