

Drug Therapy Guidelines

Gonadotropin-Releasing Hormone Agonists- Fensolvi® (leuprolide acetate), Camcevi, Lupaneta® (leuprolide, norethindrone pack), Lupron-Depot®, Lupron Depot-Ped®, Triptodur™ (triptorelin), Synarel® (nafarelin acetate)

Applicable*

Medical Benefit	x	Effective: 7/1/22
Pharmacy- Formulary 1	x	Next Review: 3/23
Pharmacy- Formulary 2	x	Date of Origin: 4/99
Pharmacy- Formulary 3/Exclusive	x	Review Dates: 4/1/99, 11/28/00, 11/27/01, 11/19/02, 12/16/03, 11/16/04, 12/7/05, 1/15/06, 10/15/06, 11/5/07, 12/15/08, 12/09, 9/11, 9/12, 9/13, 9/14, 3/15, 3/16, 3/17, 12/17, 3/18, 12/18, 3/19, 3/20, 6/20, 3/21, 9/21, 4/22
Pharmacy- Formulary 4/AON	x	

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 determined through a prior authorization process with supporting clinical documentation

III. Policy

Coverage for Camcevi and Lupron Depot 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 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

- Camcevi: 42mg 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)
 - All other indications: 11.25mg every 3 months (22.5mg every 6 months)
- Lupaneta:
 - leuprolide: 11.25mg every 3 months
 - norethindrone 5mg tablets: 90 every 3 months
- Triptodur: 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

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
- 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

- 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 norethindrone oral tablets
 - J3490
 - Available as a medical benefit
- Lupron Depot/Lupron Depot Ped

- Available as 3.75mg, 7.5mg, 11.25mg, 15mg, 30mg, 45mg powder for suspension
- J1950 - 1 billable unit equals 3.75 mg
- 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
 - J3316: 1 billable unit equals 3.75 mg
 - Available as medical benefit
- Fensolvi
 - Available as a 45 mg single dose vial in a kit with a prefilled syringe containing diluent for reconstitution
 - J1951: 1 billable unit equals 3.75 mg
 - Available as a medical benefit
- Camcevi
 - Available as a medical benefit
- Pertinent diagnoses:
 - 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

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

- Added requirement for periodic bone mineral density screening when treating endometriosis or fibroids for over 12 months
- 3/15/15: Addition of coverage criteria in the setting of gender dysphoria
- 7/1/15: formulary distinctions made
- 10/1/15: ICD9 references omitted
- 6/15/16: no policy changes
- 4/5/17: removed requirement for obtaining documentation of informed consent and laboratory testing when requested for the treatment of gender dysphoria
- 1/1/18: coverage criteria updated to allow use as supported by current NCCN guidelines; requests for all diagnostic codes will require prior authorization; addendum with diagnostic codes exceptions removed; addition of Triptodur and billing/coding information updated
- 1/10/18: clarified coverage criteria for the treatment of prostate cancer
- 5/1/18: added Synarel to policy; moved Trelstar from Abbreviated Criteria; updated ICD-10 codes; updated quantity limits and coverage duration
- 2/15/19: added Lutrate Depot to policy; added coverage for stimulation testing for CPP
- 5/15/19: updated coverage duration for CPP; updated quantity limitations; updated renewal criteria for prostate cancer
- 5/1/20: no policy changes
- 8/1/20: added Fensolvi to policy
- 10/1/20: Lupron Depot will not require a PA for the following ICD 10 code: C61 (prostate cancer)
- 5/28/21: no policy changes
- 7/1/21: updated Fensolvi billing/coding information
- 11/1/21: removed Trelstar, Eligard, Lupron (J9217), Leuprolide and Lutrate from the policy, updated billing/coding, added Camcevi
- 7/1/22: no policy changes

IX. References

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**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

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.