Drug Policy:

LHRH (agonists and antagonist)

POLICY NUMBER UM ONC_1041	**SUBJECT** Luteinizing Hormone Releasing Hormone (LHRH) Agonists and Antagonist [Lupron IM/Camcevi SC Depot (leuprolide), Trelstar (triptorelin), Zoladex (goserelin), Vantas (histrelin), Firmagon (degarelix), Orgovyx (relugolix)]	**DEPT/PROGRAM** UM Dept	**PAGE 1 OF 5**
DATES COMMITTEE REVIEWED 01/12/11, 03/13/13, 02/12/14, 06/10/15, 10/12/15, 12/09/15, 08/25/16, 10/20/16, 11/08/16, 08/10/17, 08/08/18, 07/10/19, 08/14/19, 12/11/19, 08/12/20, 09/25/20, 10/14/20, 11/11/20, 12/09/20, 01/13/21, 02/10/21, 05/12/21, 09/08/21, 11/15/21, 02/09/22	**APPROVAL DATE** February 9, 2022	**EFFECTIVE DATE** February 25, 2022	**COMMITTEE APPROVAL DATES** 01/12/11, 03/13/13, 02/12/14, 06/10/15, 10/12/15, 12/09/15, 08/25/16, 10/20/16, 11/08/16, 08/10/17, 08/08/18, 07/10/19, 08/14/19, 12/11/19, 08/12/20, 09/25/20, 10/14/20, 11/11/20, 12/09/20, 01/13/21, 02/10/21, 05/12/21, 09/08/21, 11/15/21, 02/09/22
PRIMARY BUSINESS OWNER: UM		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee	
URAC STANDARDS HUM 1	**NCQA STANDARDS** UM 2		**ADDITIONAL AREAS OF IMPACT**
CMS REQUIREMENTS	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** Commercial, Exchange, Medicaid

I. PURPOSE

To define and describe the accepted indications for LHRH agonists or antagonist [Lupron IM//Camcevi SC Depot (leuprolide), Trelstar (triptorelin), Zoladex (goserelin), Firmagon (degarelix), Vantas (histrelin), Orgovyx (relugolix)] usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century Health (NCH) is responsible for processing all medication requests from network ordering providers. Medications not authorized by NCH may be deemed as not approvable and, therefore, not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

A. PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:

1. When health plan Medicaid coverage provisions—including any applicable PDLs (Preferred Drug Lists)—conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the Preferred Drug Guidelines OR
2. When health plan Exchange coverage provisions-including any applicable PDLs (Preferred Drug Lists)-conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the Preferred Drug Guidelines OR
3. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the Preferred Drug Guidelines shall follow NCH L1 Pathways when applicable, otherwise shall follow NCH drug policies AND
4. Continuation requests of previously approved, non-preferred medication are not subject to this provision AND
5. When applicable , generic alternatives are preferred over brand-name drugs.

B. Prostate Cancer

1. Per NCH pathway & NCH policy the preferred LHRH analogs for the treatment of prostate cancer are Trelstar (J3315 triptorelin) and Lupron Depot/Eligard (J9217 leuprolide acetate 7.5 mg, 22.5 mg, 30 mg, or 45 mg.
2. The non-preferred LHRH analogs are Lupron Depot (J1950 leuprolide acetate 3.75 mg or 11.25 mg), Camcevi SC Depot (J1952 leuprolide mesylate), Zoladex (J9202 goserelin), Firmagon (J9155 degarelix), Vantas (J9225 histrelin), and Orgovyx (J8999 relugolix).
3. The above recommendations are based on the lack of Level 1 evidence (randomized trials and/or meta-analyses) showing superior outcomes with one LHRH analog over another in the treatment of prostate cancer, unless the member is intolerant to, has a contraindication to, or failure on the preferred LHRH analogs.

C. Breast Cancer

1. NOTE: Trelstar (J3315 triptorelin) and Lupron Depot/Eligard (J9217 leuprolide acetate 7.5 mg or 22.5 mg) are the preferred LHRH analogs over Lupron Depot (J1950 leuprolide acetate 3.75 mg or 11.25 mg) and Zoladex (J9202 goserelin), in members with ER/PR + breast cancer for all curative and palliative settings. This recommendation is based on the lack of Level 1 evidence (randomized trial and or meta-analysis) showing superior outcomes with one LHRH analog over another, unless the member is intolerant to, has a contraindication to, or failure on the preferred LHRH analogs.

D. Fertility Preservation in Women Undergoing Cytotoxic Chemotherapy

1. NOTE: Trelstar (J3315 triptorelin) and Lupron Depot/Eligard (J9217 leuprolide acetate 7.5 mg or 22.5 mg) are the preferred LHRH analogs over Lupron Depot (J1950 3.75 mg or 11.25 mg) and Zoladex (J9202 goserelin) and may be used in female members who are receiving chemotherapy and desire fertility preservation. This recommendation is based on the lack of Level 1 evidence (randomized trial and or meta-analysis) showing superior outcomes with one LHRH analog over another, unless the member is intolerant to, has a contraindication to, or failure on the preferred LHRH analogs.

III. EXCLUSION CRITERIA

A. Zoladex (goserelin), Trelstar (triptorelin), or Lupron Depot (leuprolide acetate) is being used in postmenopausal female member.

B. Zoladex (goserelin), Trelstar (triptorelin), or Lupron (Leuprolide) is being used in member with hormone receptor negative (ER and/or PR negative) breast cancer, except when being used for fertility preservation or for other non-cancer indications.

C. Camcevi SC Depot (J1952 leuprolide mesylate), Firmagon (J9155 degarelix), Vantas (J9225 histrelin), or Orgovyx (J8999 relugolix) is being used in members with breast cancer or for fertility preservation in women undergoing cytotoxic chemotherapy

D. Dosing exceeds single dose limit of Lupron Depot/Eligard (leuprolide acetate) IM depot 45 mg every 6 months, Camcevi SC Depot (leuprolide meseylate) 42 mg every 6 monthsZoladex (goserelin)10.8 mg every 3 months, Trelstar (triptorelin) 22.5 mg every 6 months, Vantas/Supprelin LA (histrelin) 50 mg every 12 months, Firmagon (degarelix) 240 mg (for loading dose) or 80 mg every month (continuation dose), and Orgovyx (relugolix) 360 mg (for loading dose) or 120 mg (continuation dose).

E. Treatment exceeds the maximum limit of Orgovyx (relugolix) 30 (120 mg) tablets per month.

F. Investigational use of [Lupron IM//Camcevi SC Depot (leuprolide), Trelstar (triptorelin), Zoladex (goserelin), Firmagon (degarelix), Vantas (histrelin), Orgovyx (relugolix)] with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:

1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definition of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of < 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
4. Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
5. That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
7. That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

IV. MEDICATION MANAGEMENT

A. Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

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K. Trelstar prescribing information. Verity Pharmaceuticals, Inc. Wayne, PA 2020.

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S. Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

VIII. ADDENDUM

A. For Fidelis Care 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 the use of LHRH analogs for fertility preservation in woman undergoing cytotoxic chemotherapy.