Drug Policy:

Luteinizing Hormone Releasing Hormone (LHRH) Agonists and Antagonists

POLICY NUMBER UM ONC_1041	**SUBJECT** Luteinizing Hormone Releasing Hormone (LHRH) Agonists and Antagonists [Eligard/Lupron/Lutrate Depot IM (leuprolide acetate), Camcevi SC Depot (leuprolide mesylate),Trelstar (triptorelin acetate), Zoladex (goserelin acetate), Firmagon (degarelix), Orgovyx (relugolix)]	**DEPT/PROGRAM** UM Dept	**PAGE 1 OF 4**
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, 05/11/22, 07/13/22, 12/14/22, 02/08/23, 03/08/23, 05/10/23, 08/09/23, 10/11/23, 07/10/24	**APPROVAL DATE** July 10, 2024	**EFFECTIVE DATE** July 26, 2024	**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, 05/11/22, 07/13/22, 12/14/22, 02/08/23, 03/08/23, 05/10/23, 08/09/23, 10/11/23, 07/10/24
PRIMARY BUSINESS OWNER: UM		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee	
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 Luteinizing Hormone Releasing Hormone (LHRH) Agonists or Antagonists [Eligard/Lupron IM/Lutrate Depot (leuprolide acetate), Camcevi SC Depot (leuprolide mesylate), Trelstar (triptorelin acetate), Zoladex (goserelin acetate), Firmagon (degarelix), Orgovyx (relugolix)] usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent 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. Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided:

1. The requested medication was used within the last year, AND
2. The member has not experienced disease progression and/or no intolerance to the requested medication, AND
3. Additional medication(s) are not being added to the continuation request.

B. Breast Cancer

1. Luteinizing Hormone Releasing Hormone (LHRH) Agonists (leuprolide acetate, goserelin, or triptorelin) may be used in combination with endocrine therapy (e.g., tamoxifen, aromatase inhibitors) for ovarian suppression in premenopausal women and in men with ER/PR positive breast cancer as adjuvant therapy or as therapy for recurrent/metastatic disease.

C. Fertility Preservation in Women Undergoing Cytotoxic Chemotherapy

1. For women undergoing cytotoxic chemotherapy, Luteinizing Hormone Releasing Hormone (LHRH) Agonists (leuprolide acetate, goserelin, or triptorelin) may be used in conjunction with fertility preservation methods.

D. Prostate Cancer

1. Luteinizing Hormone Releasing Hormone (LHRH) Agonists and Antagonists (leuprolide acetate/mesylate, goserelin, triptorelin, degarelix, or relugolix) may be used as a single agent or in combination with an antiandrogen with or without chemotherapy for the treatment of castrate sensitive or castrate resistant M0 or M1 prostate cancer.

III. EXCLUSION CRITERIA

A. Dosing exceeds single dose limits. of Lupron Depot/Eligard (leuprolide acetate) IM Depot 45 mg every 6 months, Lutrate Depot (leuprolide acetate) 22.5 mg every 3 months, Camcevi SC Depot (leuprolide meseylate) 42 mg every 6 months, Zoladex (goserelin)10.8 mg every 3 months, Trelstar (triptorelin) 22.5 mg every 6 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).

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

C. Investigational use of [Lupron IM/Lutrate Depot/Camcevi SC Depot (leuprolide), Trelstar (triptorelin), Zoladex (goserelin), Firmagon (degarelix), 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 definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
4. Whether the experimental design, considering 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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U. 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.