Pharmacy Medical Necessity Guidelines
Leuprolide, Lupron®, Lupron-Depot®, Lupron Depot-Ped®, Eligard® (leuprolide)

Effective: October 1, 2014

<table>
<thead>
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<th>Clinical Documentation and Prior Authorization Required</th>
<th>V</th>
<th>Type of Review – Case Management</th>
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<tr>
<td>Not Covered</td>
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<td>Type of Review – Clinical Review</td>
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<td>Fax: 617-673-0988</td>
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<tr>
<td>Pharmacy (RX) or Medical (MED) Benefit</td>
<td>RX</td>
<td>Department to Review</td>
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OVERVIEW
FDA-APPROVED INDICATIONS
Eligard® is indicated for the palliative treatment of advanced prostate cancer.
Lupron Depot-Ped® is indicated in the treatment of children with central precocious puberty.
Lupron Depot® is indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions.

PHARMACY COVERAGE GUIDELINES
Tufts Health Plan – Network Health may authorize coverage of Lupron®, Lupron-Depot®, Lupron Depot-Ped®, Eligard® (leuprolide) for members when all the following criteria are met and limitations do not apply:

Endometriosis (Lupron, Lupron Depot)
• Member has tried and failed therapy with, or is there a contraindication or intolerance to, hormonal therapy with one of the following: oral contraceptives, progestins or androgens OR
• Member is new to Tufts Health Plan – Network Health and was stabilized on leuprolide for endometriosis prior to enrollment.

Infertility (Lupron, Lupron Depot)
• The request is for the subcutaneous formulation of leuprolide. AND
• The member is enrolled in a commercial line of business.

Precocious Puberty (Lupron Depot-Ped)
• Member is a female less than 11 years of age or male less than 12 years of age.

Uterine Fibroid Tumors (Lupron, Lupron Depot)
• Member has diagnosis of uterine fibroid tumors.

Oncology (Eligard, Lupron, Lupron Depot)
• Member has a diagnosis of prostate cancer. OR
• Member has another form of cancer and do treatment guidelines (such as NCCN Clinical Practice Guidelines etc...) support the use of leuprolide for this condition.

Off-label Use Coverage for Other Cancer Diagnoses
Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the “Sullivan Law”: (M.G.L. c.175, s.47K).

Tufts Health Plan – Network Health may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a “Medically Accepted Indication” according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

Note: Tufts Health Plan-Network Health requires prescribers to submit clinical documentation supporting the drug’s effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).
In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, Tufts Health Plan - Network Health will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other “Standard Reference Compendia” noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

"Standard Reference Compendia"
1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)

"Peer Reviewed Medical Literature"
- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Gynecologic Oncology
- International Journal of Radiation Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

When Tufts Health Plan - Network Health evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:
1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
   a) 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.);
   b) 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; and,
   c) that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

LIMITATIONS
1. Initial requests will be approved for the following durations:
   a. Endometriosis: 6 months
   b. Infertility: duration of infertility services approved
   c. Precocious Puberty: Until the age of 11 if female or the age of 12 if male
   d. Uterine Fibroid Tumors: 3 months
   e. Prostate cancer or other forms of cancer: life of plan
2. Subsequent authorizations for endometriosis may be given in 12 month intervals when the member meets the following criteria:
   a. Member has been on leuprolide therapy for less than 12 months AND
   b. Member is concurrently receiving leuprolide with add-back progestin therapy, or add-back estrogen-progestin therapy OR
c. Provider indicates clinical inappropriateness to hormonal therapy and alternative regimens (i.e. low dose leuprolide or longer dosing intervals) or alternative agents being prescribed to address leuprolide’s hypoestrogenic (bone density) effects, or is BMD closely monitored. **OR**

d. Member has been on leuprolide therapy for 12 months or greater **AND**

e. Member has tried and failed surgical interventions, or did the provider indicate surgical interventions are not indicated for this patient **AND**

f. Member is concurrently receiving leuprolide with add-back progestin therapy, **OR** add-back estrogen-progestin therapy **OR**

g. Provider indicates clinical inappropriateness to hormonal therapy and alternative regimens (i.e. low dose leuprolide or longer dosing intervals) or alternative agents being prescribed to address leuprolide’s hypoestrogenic (bone density) effects, or is BMD closely monitored.

3. Subsequent authorizations for endometriosis may be given up to 3 months when the member meets the following criteria:

a. Member has been on leuprolide therapy for 12 months or greater **AND**

b. Member has not tried and failed surgical interventions, or did the provider indicate surgical interventions are not indicated for this patient **AND**

c. Member has related surgery in the near future.

4. Subsequent authorizations for uterine fibroid tumors may be given in 12 month intervals when the member meets the following criteria:

a. Member has tried and failed surgical interventions, or did the provider indicate surgical interventions are not indicated for this patient **AND**

b. Member is concurrently receiving leuprolide with add-back progestin therapy, **OR** add-back estrogen-progestin therapy **OR**

c. Provider indicates clinical inappropriateness to hormonal therapy and alternative regimens (i.e. low dose leuprolide or longer dosing intervals) or alternative agents being prescribed to address leuprolide’s hypoestrogenic (bone density) effects, or is BMD closely monitored.

5. Subsequent authorizations for endometriosis may be given up to 3 months when the member meets the following criteria:

a. Member has not tried and failed surgical interventions, or did the provider indicate surgical interventions are not indicated for this patient **AND**

b. Member has related surgery in the near future.

6. Subsequent authorizations for infertility will be approved based upon the approval of medical infertility services.

**CODES**

The following HCPCS/CPT code(s) are:

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<th>Code</th>
<th>Description</th>
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<tr>
<td>J1950</td>
<td>Injection, leuprolide acetate (for depot suspension), per 3.75 mg</td>
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<tr>
<td>J9217</td>
<td>Leuprolide acetate (for depot suspension), 7.5 mg</td>
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<tr>
<td>J9218</td>
<td>Leuprolide acetate, per 1 mg</td>
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4. Lupron Depot Prescribing Information, Abbott Pharmaceuticals Incorporated, © 2012..

**APPROVAL HISTORY**

- 10/2006: Reviewed by the Pharmacy and Therapeutics Committee
- 8/12/14: Reviewed by the Pharmacy and Therapeutics Committee
BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.