Supprelin LA® (histrelin acetate)

Effective: 9/1/15

Clinical documentation and prior authorization required: ✓

Type of review – case management

Not covered: ✓

Type of review – clinical review
Fax: 617-673-0988

Pharmacy (RX) or medical (MED) benefit: MED / RX
Department to review: RxUM

OVERVIEW

FDA-APPROVED INDICATIONS

Supprelin LA (histrelin acetate) subcutaneous implant is a gonadotropin releasing hormone (GnRH) agonist indicated for the treatment of children with central precocious puberty (CPP).

PHARMACY COVERAGE GUIDELINES

Tufts Health Plan – Network Health may authorize coverage of Supprelin LA (histrelin acetate) for members when all the following criteria are met and limitations do not apply:

1. Member has been evaluated by a specialist (i.e., endocrinologist) AND
2. The request is for the treatment of central precocious puberty (CPP) AND
3. The request is for a female Member between the ages of 2 and 11 years of age or a male Member between the ages of 2 and 12 years of age.

LIMITATIONS

1. Initial requests will be approved until the age of 11 for female Members or the age of 12 for male Members.

CODES

The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9226</td>
<td>Histrelin implant (Supprelin LA), 50 mg</td>
</tr>
</tbody>
</table>

REFERENCES


**APPROVAL HISTORY**
- 10/18/2012: Reviewed at Pharmacy and Therapeutics Committee.
- 8/12/2014: Reviewed at Pharmacy and Therapeutics Committee.
- 8/11/2015: No changes.

**BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION**
Pharmacy Medication Request 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 Medication Request 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 Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to all insured offerings unless otherwise noted in this policy or the applicable *Member Handbook*. Check the applicable *Preferred Drug List* (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 the *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.