

## Clinical Policy: Histrelin Acetate (Vantas, Supprelin LA)

Reference Number: CP.PHAR.172

Effective Date: 02/16

Last Review Date: 02/17

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene<sup>®</sup> medical policy for the use of histrelin acetate (Vantas<sup>®</sup> and Supprelin LA<sup>®</sup>).

### Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Vantas and Supprelin LA are **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Prostate Cancer (must meet all):

1. Request is for Vantas;
2. Diagnosis of prostate cancer;
3. Meets a or b:
  - a. FDA approved use:
    - i. Prescribed as palliative therapy for advanced prostate cancer (stage T3 through T4 or high risk through nodal/metastatic disease);
  - b. Off-label NCCN recommended use:
    - i. Prescribed for one of the following uses:
      - a) As adjuvant therapy (i.e., administered after radical prostatectomy [RP] if positive for pelvic lymph nodes);
      - b) As initial androgen deprivation therapy (ADT) for intermediate risk\*, high risk\*, very high risk\*, or regional (local nodal metastasis)/metastatic disease;
      - c) As ADT for biochemical failure\*\* following RP or positive digital rectal examination post radiation therapy;
      - d) For progressive castration-naïve disease (i.e., not on ADT at time of progression) or castration-recurrent/resistant disease (i.e., no longer responsive to traditional ADT);
4. Documentation showing a history of  $\geq 3$  months of gonadotropin-releasing hormone (GnRH) agonist injections that were effective and well tolerated;
5. No known hypersensitivity to GnRH, GnRH analogs, or any excipient in the requested product.

*\*Intermediate risk (clinical stage T2b to T2c, Gleason score 7/Gleason grade group 2-3, or prostatic specific antigen [PSA] value 10 ng/mL to 20 ng/mL); high risk (clinical stage T3a, Gleason score 8-10/Gleason grade group 4-5 or PSA value >20 ng/mL); very high risk (clinical stage T3b-T4, Gleason pattern 5, or more than 4 biopsy cores with Gleason score 8-10/Gleason grade group 4-5).*

*\*\*Biochemical failure: 1) Failure of PSA to fall to undetectable levels (PSA persistence) or 2) undetectable PSA after RP with a subsequent detectable PSA that increases on 2 more determinations (PSA recurrence).*

**Approval duration: 12 months**  
*(One 12-month implant)*

**B. Central Precocious Puberty** (must meet all):

1. Request is for Supprelin LA;
2. Females age  $\geq 2$  and  $\leq 11$  years, or males age  $\geq 2$  and  $\leq 12$  years;
3. Diagnosis of central precocious puberty (CPP) confirmed by (a through c):
  - a. Elevated basal luteinizing hormone (LH) level  $> 0.2 - 0.3$  mIU/L (dependent on type of assay used) and/or elevated leuprolide-stimulated LH level  $> 3.3 - 5$  IU/I (dependent on type of assay used);
  - b. Bone age  $\geq 1$  year advanced of chronological age;
  - c. Age at onset of secondary sex characteristics is  $< 8$  years if female, or  $< 9$  years if male;
4. Prescribed dose of Supprelin LA does not exceed one 50 mg implant every 12 months;
5. Member has none of the following contraindications:
  - a. Known hypersensitivity to GnRH, GnRH analogs, or any excipient in the requested product;
  - b. If female, pregnancy.

**Approval duration: 12 months**  
*(One 12-month implant)*

**C. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy**

**II. Continued Approval**

**A. Prostate Cancer** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Request is for Vantas;
3. Member is responding positively to therapy;
4. Prescribed dose of Vantas does not exceed one 50 mg implant every 12 months;
5. No known hypersensitivity to GnRH, GnRH analogs, or any excipient in the requested product.

**Approval duration: 12 months**  
*(One 12-month implant)*

**B. Central Precocious Puberty** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Request is for Supprelin LA;
3. Member is responding positively to therapy;
4. Females, age  $\geq 2$  and  $\leq 11$  years, or males, age  $\geq 2$  and  $\leq 12$  years;

5. Therapeutic effect is evidenced by decreased growth velocity, menses cessation if female, and arrested pubertal progression.
6. Prescribed dose of Supprelin LA does not exceed one 50 mg implant every 12 months;
7. Member has none of the following contraindications:
  - a. Known hypersensitivity to GnRH, GnRH analogs, or any excipient in the requested product;
  - b. If female, pregnancy.

**Approval duration: 12 months**  
*(One 12-month implant)*

- C. **Other diagnoses/indications** (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
  2. Refer to CP.PHAR.57 - Global Biopharm Policy.

### **Background**

#### *Description/Mechanism of Action:*

Histrelin acetate is a GnRH agonist that acts as a potent inhibitor of gonadotropin secretion when given continuously in therapeutic doses.

#### *Formulations:*

Histrelin acetate for subcutaneous administration:

Supprelin LA: 50 mg implant

- Designed to deliver approximately 65 mcg histrelin acetate per day over 12 months.

Vantas: 50 mg implant

- Designed to deliver approximately 50 mcg histrelin acetate per day over 12 months.

#### *FDA Approved Indications:*

- Vantas is a GnRH agonist/subcutaneous implant indicated for the palliative treatment of advanced prostate cancer.
- Supprelin LA is a GnRH agonist/subcutaneous implant indicated for the treatment of children with central precocious puberty (CPP).

### **Appendices**

#### **Appendix A: Abbreviation Key**

ADT: Androgen deprivation therapy

LH: Luteinizing hormone

CPP: Central precocious puberty

PSA: Prostate specific antigen

GnRH: Gonadotropin-releasing hormone

RP: Radical prostatectomy

### **Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-

date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<b>HCPCS Codes</b>	<b>Description</b>
J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA) 50mg

<b>Reviews, Revisions, and Approvals</b>	<b>Date</b>	<b>Approval Date</b>
Policy split from CP.PHAR.118.GnRH Analogs. Prostate cancer – advanced/palliative; added age 18 or older per PI; max dose added; Removed preferencing; staging of advanced prostate cancer restated as stage T3 through T4 or high risk through nodal/metastatic disease per guidelines; added confirmation that treatment intent is palliative if designated in PI; approval period extended to q 12 months CPP – added age lower range of 2 per PIs; max dose added; added additional rule-outs per PI; removed required high estradiol and testosterone levels (stimulated) as threshold concentrations are not clear (UpToDate); removed >1 year from advanced bone age – replaced with wording from UpToDate and PI that is not as specific; approval period: restated as q 12 months if ≤ 11 years and female or ≤ 12 year and male;	02/16	02/16
CPP: Removed lower age limit of 2 years, made bone age specifically ≥ 1 year advanced age; removed conditions that must be ruled out per specialist review.	05/16	
Prostate cancer: Age removed – while safety and effectiveness in pediatric patients has not been established per the PI, the PI stops short of recommending that Vantus not be used in pediatrics. NCCN recommendations added (prostate cancer; doses removed). Formulations added. Added HCPCS Codes for Vantas and Supprelin LA implants	02/17	02/17

**References**

1. Vantas prescribing information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; July 2014. Available at [www.endo.com](http://www.endo.com). Accessed December 28, 2016.
2. Supprelin LA prescribing information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; June 2013. Available at [www.supprelinla.com](http://www.supprelinla.com). Accessed December 28, 2016.
3. Histrelin acetate. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at [NCCN.org](http://NCCN.org). Accessed December 29, 2016.
4. Prostate cancer (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at [NCCN.org](http://NCCN.org). Accessed December 29, 2016.
5. Harrington J and Palmert MR. Definition, etiology, and evaluation of precocious puberty. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at [UpToDate.com](http://UpToDate.com). Accessed December 28, 2016.

- Harrington J and Palmert MR. Treatment of precocious puberty. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed December 28, 2016.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid 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 this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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