Clinical Policy: Goserelin Acetate (Zoladex)

Reference Number: CP.PHAR.171
Effective Date: 10.01.16
Last Review Date: 11.17
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Goserelin acetate (Zoladex®) is a gonadotropin-releasing hormone (GnRH) receptor agonist.

FDA Approved Indication(s)

Zoladex is indicated for:

- Use in combination with flutamide for the management of locally confined Stage T2b-T4 (Stage B2-C) carcinoma of the prostate; treatment with Zoladex and flutamide should start 8 weeks prior to initiating radiation therapy and continue during radiation therapy:
  - Zoladex – 3.6 mg implant; 10.8 mg implant
- Palliative treatment of advanced carcinoma of the prostate:
  - Zoladex – 3.6 mg implant; 10.8 mg implant
- Management of endometriosis, including pain relief and reduction of endometriotic lesions for the duration of therapy; experience with Zoladex for the management of endometriosis has been limited to women 18 years of age and older treated for 6 months:
  - Zoladex – 3.6 mg implant
- Use as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding:
  - Zoladex – 3.6 mg implant
- Use in the palliative treatment of advanced breast cancer in pre- and perimenopausal women:
  - Zoladex – 3.6 mg implant

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Zoladex is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all):

1. Request is for Zoladex (3.6 mg and/or 10.8 mg);
2. Diagnosis of prostate cancer;
3. Age ≥ 18 years;
4. Meets (a or b):
   a. FDA approved use:

i. In combination with flutamide for the management of locally confined stage T2b-T4 (stage B2-C) disease;
ii. Palliative treatment of advanced disease:

b. NCCN recommended use (any of the following):
i. Adjuvant androgen deprivation therapy (ADT) as a single agent or in combination with an antiandrogen if positive lymph nodes found during pelvic lymph node dissection;
ii. Initial ADT as a single agent or in combination with an antiandrogen (a, b or c):
a) With radiation therapy for (1, 2 or 3):
1) Intermediate risk disease;
2) High or very high risk disease +/- docetaxel;
3) Regional disease (any T, N1, M0);
b) For very high risk disease if not a candidate for definitive therapy;
c) For regional disease (any T, N1, M0) or metastatic disease (M1);
iii. ADT as a single agent or in combination with an antiandrogen (a or b):
a) For biochemical failure following radical prostatectomy (1 or 2):
1) With radiation therapy if no distant metastases;
2) +/- radiation therapy if distant metastases;
b) For positive digital rectal examination following radiation therapy (1 or 2):
1) If biopsy is negative and there are no distant metastases;
2) If not a candidate for local therapy;
iv. For progressive castration-naive disease (a, b or c):
a) As a single agent;
b) With an antiandrogen;
c) With docetaxel +/- prednisone +/- an antiandrogen for metastatic (M1) disease;
v. For castration-recurrent disease to maintain castrate levels of serum testosterone as a single agent or with an antiandrogen;

5. Request meets one of the following:
a. Dose does not exceed Zoladex (SC): 3.6 mg/month or 10.8 mg/3 months;
b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

C. Endometriosis (must meet all):
1. Request is for Zoladex (3.6 mg);
2. Diagnosis of endometriosis and (a or b):
a. Surgically confirmed;
b. Clinically suspected and member has failed a 3-month trial of one of the following agents within the last year or has a documented intolerance or contraindication to the agent (i, ii or iii):
i. A nonsteroidal anti-inflammatory drug;
ii. An oral or depot contraceptive;
iii. A progestin;
3. Prescribed by or in consultation with a gynecologist;

4. Age ≥ 18 years;
5. At the time of request, member is not pregnant.
6. Dose does not exceed Zoladex (SC): 3.6 mg/month.

Approval duration: 6 months

D. Dysfunctional Uterine Bleeding (must meet all):
1. Request is for Zoladex (3.6 mg);
2. Diagnosis of dysfunctional uterine bleeding;
3. Prescribed as an endometrial-thinning agent prior to endometrial ablation;
4. Prescribed by or in consultation with a gynecologist;
5. Age ≥ 18 years;
6. At the time of request, member is not pregnant.
7. Dose does not exceed Zoladex (SC): 3.6 mg/month.

Approval duration: 2 implants

B. Breast Cancer (must meet all):
1. Request is for Zoladex (3.6 mg);
2. Diagnosis of breast cancer;
3. Age ≥ 18 years;
4. Member is pre/peri-menopausal;
5. Member meets (a or b):
   a. FDA approved use:
      i. Palliative therapy for advanced disease;
   b. NCCN recommended use:
      i. In combination with (a or b):
         a) Adjuvant endocrine therapy (e.g., tamoxifen or an aromatase inhibitor) for hormone receptor-positive disease;
         b) Endocrine therapy for recurrent or stage IV disease;
6. At the time of request, member is not pregnant;
7. Request meets one of the following:
   a. Dose does not exceed Zoladex (SC): 3.6 mg/month;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications
1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Prostate Cancer (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for Zoladex (3.6 mg and/or 10.8 mg);
3. Member is responding positively to therapy (e.g., improved quality of life; no unacceptable toxicity);

4. If request is for a dose increase, request meets one of the following:
   a. New dose does not exceed Zoladex (SC): 3.6 mg/month, 10.8 mg/3 months;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval duration: 12 months

B. Endometriosis (must meet all):
1. Previously received medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for Zoladex (3.6 mg);
3. Member is responding positively to therapy (e.g., improvement in dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, size of endometrial lesions);
4. If request is for a dose increase, new dose does not exceed Zoladex (SC): 3.6 mg/month.

Approval duration: 6 months
Total duration of therapy should not exceed 12 months.

C. Dysfunctional Uterine Bleeding (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for Zoladex (3.6 mg);
3. Member is responding positively to therapy (e.g., improvement in dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, size of endometrial lesions);
4. If request is for a dose increase, new dose does not exceed Zoladex (SC): 3.6 mg/month.

Approval duration: 2 implants total

D. Breast Cancer (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for Zoladex (3.6 mg);
3. Member is responding positively to therapy (e.g., improved quality of life; no unacceptable toxicity);
4. If request is for a dose increase, request meets one of the following:
   a. New dose does not exceed Zoladex (SC): 3.6 mg/month;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

E. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GnRH: gonadotropin-releasing hormone
NCCN: National Comprehensive Cancer Network
SC: subcutaneous

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Prostate cancer*	Zoladex (SC): 3.6 mg/month, 10.8 mg/3 months	See regimen
Endometriosis	Zoladex (SC): 3.6 mg/month	See regimen
Dysfunctional uterine bleeding	Zoladex (SC): 3.6 mg/month	See regimen
Breast cancer	Zoladex (SC): 3.6 mg/month	See regimen

**May be used in combination with therapies such as radiation therapy, antiandrogens, glucocorticoids, docetaxel.*

VI. Product Availability

Drug Name	Availability
Goserelin acetate (Zoladex 3.6)	Monthly 3.6 mg implant
Goserelin acetate (Zoladex 10.8)	Three-month 10.8 mg implant

VII. References

1. Zoladex (3.6 mg) Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2016. Available at https://www.zoladexhcp.com. Accessed July 26, 2017.
2. Zoladex (10.8 mg) Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2016. Available at https://www.zoladexhcp.com. Accessed July 26, 2017.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Goserelin acetate. Available at nccn.org. Accessed July 26, 2017.
4. National Comprehensive Cancer Network. Prostate cancer (Version 2.2017). Available at nccn.org. Accessed July 26, 2017.
5. National Comprehensive Cancer Network. Breast cancer (Version 2.2017). Available at nccn.org. Accessed July 26, 2017.
6. Committee on Practice Bulletins - Gynecology. Management of endometriosis. July 2010 (reaffirmed 2016); 116(1): 223-236.

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.

HCPCS Codes	Description
J9202	Goserelin acetate implant, per 3.6 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.118.GnRH Analogs. Prostate cancer – locally confined with radiation therapy; age added 18 or older per PI; max dose added; staging restated per PI Approval period limited to 6 months total with radiation therapy per guidelines Prostate cancer – advanced/palliative; age added 18 or older per PI; max dose added; removed preferencing other than a trial of injectables before receiving implant; 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 Breast cancer – advanced/palliative; age added 18 or older per PI; max dose added; defined advanced as stage IV or recurrent metastatic disease per guidelines; removed requirement for ER/PR+ status as guidelines note status not always clear and that GnRH analogs can be effective in either case; add peri-menopausal status per Zoladex guideline; FDA approved and off-label breast cancer criteria is stated the same based on Zoladex PI and guidelines; added confirmation that treatment intent is palliative as designated in Zoladex PI; approval period; extended to q 12 months Endometriosis - age added 18 or older per PI; max dose added; removed that surgical diagnosis had to be within last year; for clinical diagnosis, restated failure of one three-month trial to analgesics and/or contraceptives per UpToDate; approval period restated per PIs as follows: 6 months total if Zoladex, up to 12 months total for all others per products.	02.16	02.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Endometrial thinning prior to ablation - age added 18 or older per PI; max dose added		
Endometriosis: Changed 3 month trial of analgesics and/or hormonal contraceptives to NSAIDS and/or hormonal contraceptives.	05.16	
Per the PI, pregnancy is not a contraindication in cases of advanced breast cancer so it is removed as such in sections I.B and II.B above.	10.16	
Age removed. Formulations added. Off-label NCCN recommended uses added (prostate and breast cancer; doses removed; 3-month injectable requirement removed).	01.17	02.17
Age and dosing added to oncology criteria; age added to gynecology criteria. Positive therapeutic response examples added for oncology and endometriosis criteria. Oncology FDA/NCCN (categories 1 and 2A) indications listed separately. Endometriosis step therapy edited from estrogen/progestin OC to OC or depot contraceptive or progestin. Total approval duration increased from 6 to 12 months. Specialist requirement added for endometriosis, DUB. Safety information removed with the exception of pregnancy; pregnancy added for breast cancer per expert recommendation.	09.17	11.17

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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.