Clinical Policy: Histrelin Acetate (Vantas, Supprelin LA)

Reference Number: CP.PHAR.172
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

Histrelin acetate (Vantas® and Supprelin LA®) is a gonadotropin-releasing hormone (GnRH) receptor agonist.

FDA Approved Indication(s)

- Vantas is indicated for the palliative treatment of advanced prostate cancer.
- Supprelin LA is indicated for the treatment of children with central precocious puberty (CPP).

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 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;
1. Diagnosis of prostate cancer;
2. Age ≥ 18 years;
3. Meets (a or b):
   a. FDA approved use:
      i. Palliative treatment of advanced disease:
   b. NCCN recommended use:
      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;

2. Documentation showing a history of ≥ 3 months of gonadotropin-releasing hormone (GnRH) agonist injections that were effective and well tolerated;
3. Request meets one of the following:
  a. Dose does not exceed Vantas (SC): 50 mg/12 months (one implant);
  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. Central Precocious Puberty (must meet all)**:**
1. Request is for Supprelin LA;
2. Diagnosis of central precocious puberty confirmed by (a, b and 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. Difference between bone age and chronological age was > 1 year (bone age-chronological age;
  c. Age at onset of secondary sex characteristics is < 8 years if female, or < 9 years if male;
3. Member meets the following age requirements:
  a. Female: 2 - 11 years;
  b. Male: 2 - 12 years;
4. Prescribed by or in consultation with a pediatric endocrinologist;
5. At the time of request, member is not pregnant;
6. Dose does not exceed Supprelin LA (SC): 50 mg/12 months (one implant).

Approval duration: 12 months

C. 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 Vantas;
3. Member is responding positively to therapy (e.g., improved quality of life; no unacceptable toxicity);
4. Request meets one of the following:
   a. New dose does not exceed Vantas (SC): 50 mg/12 months (one implant);
   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. 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 (e.g., decreased growth velocity, cessation of menses, softening of breast tissue or testes, arrested pubertal progression);
4. Member meets the following age requirement:
   a. Female: ≤ 11 years;
   b. Male: ≤ 12 years;
5. If request is for a dose increase, new dose does not exceed Supprelin LA (SC): 50 mg/12 months (one implant).

Approval duration: 12 months

C. 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

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

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
Histrelin acetate (Vantas [SC])	Prostate cancer*	50 mg/12 months	See regimen
Histrelin acetate (Supprelin LA [SC])	CPP	50 mg/12 months	See regimen

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

VI. Product Availability

Drug Name	Availability
Histrelin acetate (Vantas)	50 mg implant designed to deliver approximately 50 mcg histrelin acetate per day over 12 months.
Histrelin acetate (Supprelin LA)	50 mg implant designed to deliver approximately 65 mcg histrelin acetate per day over 12 months.

VII. References

1. Vantas Prescribing Information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; June 2017. Available at www.endo.com. Accessed July 26, 2017.
2. Supprelin LA Prescribing Information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; June 2013. Available at www.supprelinla.com. Accessed July 26, 2017.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Histrelin 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. Kaplowitz P, Bloch C. Evaluation and referral of children with signs of early puberty. Pediatrics. 2016; 137(1): e20153732.

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
J9225	Histrelin implant (Vantas), 50 mg
J9226	Histrelin implant (Supprelin LA) 50 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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	02.16	02.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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;		
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
Age and dosing added to prostate cancer. FDA/NCCN (categories 1 and 2A) indications listed separately. Positive therapeutic response examples added. Specialist requirement added for CPP. Safety information removed (hypersensitivity).	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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.