

Clinical Policy: Histrelin Acetate (Vantas, Supprelin LA)

Reference Number: CP.PHAR.172

Effective Date: 10.01.16

Last Review Date: 11.18

Line of Business: Medicaid, HIM-Medical Benefit

[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 (such as office chart notes, lab results or other clinical information) 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. Diagnosis of prostate cancer;
2. Request is for Vantas;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years;
1. Documentation showing a history of \geq 3 months of gonadotropin-releasing hormone (GnRH) agonist injections that were effective and well tolerated;
5. Request meets one of the following:
 - a. Dose does not exceed 50 mg per 12 months (one implant per year);
 - 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. Diagnosis of central precocious puberty confirmed by all of the following (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;
2. Request is for Supprelin LA;
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. Dose does not exceed 50 mg per 12 months (one implant per year).

Approval duration: 12 months

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prostate Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vantas for prostate cancer and has received this medication for at least 30 days;
2. Request is for Vantas;
3. Member is responding positively to therapy;
4. Request meets one of the following:
 - a. New dose does not exceed 50 mg per 12 months (one implant per year);
 - 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 50 mg per 12 months (one implant per year).

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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

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 policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

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

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Leuprolide acetate injection (generic)	Prostate Cancer - Palliative Therapy SC: 1 mg per day	1 mg per day
Eligard (leuprolide acetate)	Prostate Cancer - Palliative Therapy SC: 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, or 45 mg per 6 months	See regimen
Lupron Depot 7.5, 22.5, 30, 45 (leuprolide acetate)	Prostate Cancer - Palliative Therapy IM: 7.5 mg per 4 weeks, 22.5 mg per 12 weeks, 30 mg per 16 weeks, or 45 mg per 24 weeks	See regimen
Zoladex 3.6 (goserelin acetate)	Prostate Cancer - Palliative Therapy SC: 3.6 mg per 28 days	See regimen
Zoladex 3.6, 10.8 (goserelin acetate)	Prostate Cancer - Stage B2-C SC: 3.6 mg, 8 weeks before radiotherapy, followed by 10.8 mg in 28 days (alternative: 4 injections of 3.6 mg at 28-	See regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	day intervals, 2 preceding and 2 during radiotherapy)	

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Vantas
 - Hypersensitivity to GnRH, GnRH agonist analogs, or any of the components in Vantas.
 - Use in women and pediatric patients.
 - Pregnancy
 - Suprelin LA
 - Hypersensitivity to gonadotropin releasing hormone (GnRH) or GnRH analogs.
 - Pregnancy
- Boxed warning(s): None reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Histrelin acetate (Supprelin LA)	CPP	1 implant (50 mg) SC for 12 months	1 implant per 12 months
Histrelin acetate (Vantas)	Prostate cancer - palliative therapy	1 implant (50 mg) SC for 12 months	1 implant per 12 months

VI. Product Availability

Drug Name	Availability
Histrelin acetate (Supprelin LA)	Implant: 50 mg (approximately 65 mcg histrelin acetate per day over 12 months)
Histrelin acetate (Vantas)	Implant: 50 mg (approximately 50 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 30, 2018.
2. Supprelin LA Prescribing Information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; May 2017. Available at www.supprelinla.com. Accessed July 30, 2018.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Histrelin acetate. Available at nccn.org. Accessed July 30, 2018.
4. National Comprehensive Cancer Network. Prostate cancer (Version 3.2018). 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
<p>Policy split from CP.PHAR.118.GnRH Analogs.</p> <p>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</p> <p>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;</p>	02.16	02.16
<p>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.</p>	05.16	
<p>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.</p> <p>NCCN recommendations added (prostate cancer; doses removed).</p> <p>Formulations added.</p> <p>Added HCPCS Codes for Vantas and Supprelin LA implants</p>	02.17	02.17
<p>Age and dosing added to prostate cancer. FDA/NCCN (categories 1 and 2A) indications listed separately. Positive therapeutic response examples added.</p> <p>Specialist requirement added for CPP.</p> <p>Safety information removed (hypersensitivity).</p>	09.17	11.17
<p>4Q 2018 annual review: no significant changes; added HIM-Medical; for oncology, summarized NCCN and FDA-approved uses for improved clarity (limited to diagnosis); specialist involvement in care and continuation of care added; references reviewed and updated.</p>	08.07.18	11.18

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.

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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.

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