Clinical Policy: Histrelin Acetate (Vantas, Supprelin LA)

Reference Number: LA.PHAR.172
Effective Date:
Last Review Date: 01.21
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) 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

Prior authorization is required. 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 Louisiana Healthcare Connections 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 or urologist;**
4. **Age ≥ 18 years;**
5. **Request meets one of the following (a or b):***
   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*).**

Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration: 12 months

B. Central Precocious Puberty (must meet all):

1. **Diagnosis of CPP confirmed by all of the following (a, b, and c):**
   a. **Elevated basal concentration of luteinizing hormone (LH) (i.e., > 0.2 - 0.3 mIU/L) or leuprolide-stimulated LH (i.e., > 3.3 - 5 IU/L);***

Pubertal threshold dependent on assay used.

b. **Bone age advanced > 1 year beyond chronological age;**
c. **Age at onset of secondary sex characteristics (i or ii):**
i. **Female: < 8 years;**
ii. **Male: < 9 years;**
2. **Request is for Supprelin LA;**
3. **Prescribed by or in consultation with a pediatric endocrinologist;**
4. **Member meets one of the following age requirements (a or b):**
a. **Female: 2 to ≤ 11 years;**
b. **Male: 2 to ≤ 12 years;**
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 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

II. **Continued Therapy**
A. **Prostate Cancer (must meet all):**
1. **Currently receiving medication via Louisiana Healthcare Connections 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. **If request is for a dose increase, request meets one of the following (a or b):***
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*).**

Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration: 12 months

B. **Central Precocious Puberty (must meet all):**
1. **Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met all initial approval criteria;**
2. **Request is for Supprelin LA;**
3. **Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: decreased growth velocity, cessation of menses, softening of breast tissue or testes, arrested pubertal progression;**
4. **Member meets one of the following age requirements (a or b):**
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 Louisiana Healthcare Connections 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 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.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 policy –LA.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

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

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s): hypersensitivity to GnRH, GnRH agonist 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.; February 2019. Available at www.endo.com. Accessed July 28, 2020.**
2. **Supprelin LA Prescribing Information. Malvern, PA: Endo Pharmaceuticals Solutions, Inc.; November 2019. Available at www.supprelinla.com. Accessed July 28, 2020.**

3. **National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed July 28, 2020.**
4. **National Comprehensive Cancer Network. Prostate Cancer Version 2.2020. Available at https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed July 28, 2020.**
5. **Kaplowitz P, Bloch C. Evaluation and referral of children with signs of early puberty. Pediatrics. 2016; 137(1): e20153732.**
6. **Carel JC, Eugster EA, Rogol A, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. Pediatrics. 2009;123(4):e752. Epub 2009 Mar 30.**
7. **Krishna KB, Fuqua JS, Rogol AD, et al. Use of gonadotropin-releasing hormone analogs in children: update by an International Consortium. Horm Res Paediatr 2019;91:357–372. DOI: 10.1159/000501336.**
8. **Silverman LA, Neely EK, Kletter GB, et al. Long-term continuous suppression with once-yearly histrelin subcutaneous implants for the treatment of central precocious puberty: a final report of a phase 3 multicenter trial. J Clin Endocrinol Metab. 2015;100(6):2354-2363.**

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
Converted corporate to local policy	01.21

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.

LHCC 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.

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 LHCC administrative policies and procedures.

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