



## GnRH Prior Authorization Drug List A

<b>Drug(s) Applied:</b>	<b>Leuprolide acetate, Eligard</b> (leuprolide acetate), <b>Firmagon</b> (degarelix acetate), <b>Lupron Depot</b> (leuprolide acetate), <b>Orgovyx</b> (relugolix), <b>Vabrinty</b> (leuprolide acetate)
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### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved or compendia supported indication and all of the following criteria are met:

#### I. Initial Therapy Criteria

##### A. Prostate cancer as indicated by chart notes within past 180 days

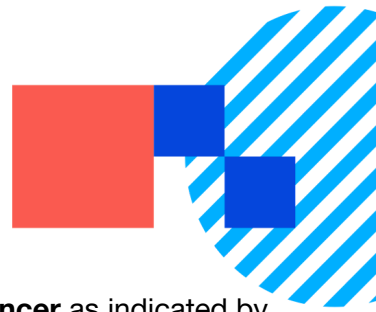
1. For Lupron Depot, Orgovyx, and Vabrinty, ONE of the following:
  - a. Patient has tried and had an inadequate response to Eligard and Firmagon **or**
  - b. Patient has an intolerance or FDA labeled contraindication to Eligard and Firmagon **and**
2. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

**Approval Duration:** 12 months

##### B. Breast cancer as indicated by chart notes within past 180 days

1. For Lupron Depot and Vabrinty, ONE of the following:
  - a) Patient has tried and had an inadequate response to Eligard **or**
  - b) Patient has an intolerance or FDA labeled contraindication to Eligard **and**
2. ONE of the following:
  - a) Patient is a pre- or perimenopausal female with breast cancer **and**
    - (1) One of the following:
      - (a) Patient will use the requested agent for fertility preservation **or**
      - (b) Patient will use the requested agent for ovarian suppression during endocrine therapy (e.g., anastrozole, letrozole, exemestane, fulvestrant, tamoxifen, etc.) **or**
    - b) Patient is a male with hormone receptor positive advanced or metastatic breast cancer receiving endocrine therapy

**Approval Duration:** 12 months



**C. Ovarian cancer, fallopian tube cancer, or primary peritoneal cancer** as indicated by chart notes within past 180 days

1. For Lupron Depot and Vabrinty, ONE of the following:
  - a) Patient has tried and had an inadequate response to Eligard **or**
  - b) Patient has an intolerance or FDA labeled contraindication to Eligard **and**
2. Patient has persistent disease or disease recurrence

**Approval Duration:** 12 months

II. Continued Therapy Criteria

**A. Prostate cancer, breast cancer, ovarian cancer, fallopian tube cancer, or primary peritoneal cancer** as indicated by chart notes within past 12 months

1. Patient meets the initial therapy criteria above

**Approval Duration:** 12 months

**Policy Owned by:** Curative PBM team