AETNA BETTER HEALTH® Coverage Policy/Guideline					
Name:	Eligard			Page:	1 of 2
Effective Date:	8/26/2024			Last Review Date:	7/2024
Applies to:	☒Florida Kids ☐Pennsylvania Kids	☒Maryland ☒Virginia		☐Michigan ☐Kentucky PRMD	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Eligard under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Treatment of advanced prostate cancer

B. Compendial Uses
1. Prostate cancer
2. Androgen receptor positive salivary gland tumors

All other indications are considered experimental/investigational and not medically necessary.

- *For Maryland requests related to gender dysphoria please use Gender Affirming Care Aetna MD Medicaid C26818-A.*
- *For Virginia requests related to gender dysphoria please use GnRH Analogs for Gender Dysphoria C22189-A Aetna Medicaid*

Applicable Drug List:

Eligard

Policy/Guideline:

Criteria for Initial Approval:

A. Prostate cancer
Authorization of 12 months may be granted for treatment of prostate cancer.

B. Salivary gland tumors
Authorization of 12 months may be granted for treatment of recurrent, unresectable or metastatic salivary gland tumors as a single agent when the tumor is androgen receptor positive.

Continuation of Therapy:

A. Authorization of 12 months may be granted for continued treatment of salivary gland tumors in members requesting reauthorization who are experiencing clinical benefit to therapy and who have not experienced an unacceptable toxicity.

B. Authorization of 12 months may be granted for continued treatment of prostate cancer in members requesting reauthorization who are experiencing clinical benefit to therapy (e.g., serum testosterone less than 50 ng/dL) and who have not experienced an unacceptable toxicity.

Approval Duration and Quantity Restrictions:

Approval: 12 months

References:

1. Eligard [package insert]. Fort Collins, CO: Tolmar Pharmaceuticals, Inc.; January 2024.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 1, 2024.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Head and Neck Cancers. Version 2.2024. Accessed February 15, 2024. https://www.nccn.org/professionals/physician_gls/pdf/head-and-neck.pdf.