

Clinical Policy: Degarelix Acetate (Firmagon)

Reference Number: CP.PHAR.170

Effective Date: 10.01.16

Last Review Date: 11.18

Line of Business: HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Degarelix acetate (Firmagon[®]) is a gonadotropin-releasing hormone (GnRH) receptor antagonist.

FDA Approved Indication(s)

Firmagon is indicated for treatment of advanced prostate cancer.

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 Firmagon is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all):

1. Diagnosis of prostate cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Request meets one of the following (a, b or c):
 - a. Starting dose does not exceed 240 mg given as two injections of 120 mg each;
 - b. Maintenance dose does not exceed 80 mg as a single injection per 28 days;
 - c. 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. 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 Firmagon for prostate cancer and has received this medication for at least 30 days;
2. Member is responding positively to therapy;

3. If request is for a dose increase, request meets one of the following:
 - a. New dose does not exceed 80 mg per 28 days (maintenance dose);
 - 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. 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

FDA: Food and Drug Administration

GnRH: gonadotropin-releasing hormone

NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives

Not applicable.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Previous hypersensitivity reactions to degarelix
 - Pregnancy
- Boxed warning(s): None reported

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|-----------------|---|--------------|
| Prostate cancer | Starting dose: 240 mg SC given as two 120 mg injections; Maintenance dose: 80 mg SC given as one injection per 28 days | See regimen |

VI. Product Availability

Vial: 80 mg (20 mg/mL), 120 mg (40 mg/mL)

VII. References

1. Firmagon Prescribing Information. Parsipanny, NJ: Ferring Pharmaceuticals Inc.; July 2016. Available at www.ferringusa.com. Accessed July 30, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Degarelix acetate. Available at nccn.org. Accessed July 30, 2018.
3. National Comprehensive Cancer Network. Prostate cancer (Version 3.2018). Available at nccn.org. Accessed July 30, 2018.

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 |
|-------------|---------------------------|
| J9155 | Injection,degarelix, 1 mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|----------|-------------------|
| Policy split from CP.PHAR.118.GnRH Analogs. 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; approval period extended to 12 months | 02.16 | 02.16 |
| Age removed. Off-label NCCN recommended uses added (prostate and breast cancer; doses removed). Formulations added. | 01.17 | 02.17 |
| Age and dosing added. Positive therapeutic response examples added. Prostate cancer FDA/NCCN (categories 1 and 2A) indications listed separately. Breast cancer removed as an off label indication per NCCN. Safety information removed (hypersensitivity). | 09.17 | 11.17 |
| 4Q 2018 annual review: no significant changes, HIM added; 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. | 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.

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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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