LOUISIANA BLUE

Gonadotropin-releasing Hormone (GnRH) Products

Policy # 00907
Original Effective Date: 01/01/2025
Current Effective Date: 01/01/2025

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services Are Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider select Gonadotropin-releasing Hormone (GnRH) products, including, but not limited to leuprolide acetate for depot suspension (Lupron Depot®, Lupron Depot-Ped®)‡, triptorelin (Triptodur®)‡, histrelin acetate subcutaneous implant (Supprelin® LA)‡, and leuprolide acetate for injectable suspension (Fensolvi®)‡ to be **eligible for coverage.****

Background/Overview

The Gonadotropin-releasing Hormone (GnRH) products mentioned in this policy (Lupron Depot-Ped, Triptodur, Supprelin LA, and Fensolvi) are approved by the Food and Drug Administration (FDA) for the treatment of Central Precocious Puberty (CPP). Lupron Depot is approved by the FDA for a multitude of uses which will not be discussed in detail within this policy. The Gonadotropin-releasing Hormone (GnRH) products listed in this policy are covered at parity status. The lack of mention of a particular Gonadotropin-releasing Hormone (GnRH) product does not insinuate that there is no coverage for that product.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The purpose of this policy is to reflect the coverage of the mentioned Gonadotropin-releasing Hormone (GnRH) products at parity status. It should be noted that these are not targeted medical drugs. This Medical Policy is informational in nature only.

References

1. Lupron Depot-Ped [package insert]. AbbVie, Inc. North Chicago, IL. Updated April 2023.
2. Lupron Depot [package insert]. AbbVie, Inc. North Chicago, IL. Updated October 2023.
3. Triptodur [package insert]. Azurity Pharmaceuticals, Inc.Woburn, MA. Updated May 2024.
4. Supprelin LA [package insert]. ENDO USA, Inc. Malvern, PA. Updated April 2022.
5. Fensolvi [package insert]. Tolmar Inc. Fort Collins, CO. Updated October 2024.

Policy History

Original Effective Date: 01/01/2025
Current Effective Date: 01/01/2025
11/07/2024 Medical Policy Committee review
11/13/2024 Medical Policy Implementation Committee approval. New policy.
Next Scheduled Review Date: 11/2025

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.