

Clinical Policy: Leuprolide Acetate (Eligard, Fensolvi, Lupron Depot, Lupron Depot-Ped, Vabrinty), Leuprolide Mesylate (Camcevi, Camcevi ETM)

Reference Number: CP.PCH.53

Effective Date: 12.01.24

Last Review Date: 02.26

Line of Business: Commercial, HIM

[Coding Implications](#)
[Revision Log](#)

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

Description

Leuprolide acetate (Eligard[®], Fensolvi[®], Lupron Depot[®], Lupron Depot-Ped[®], Vabrinty[™]) and leuprolide mesylate (Camcevi[™], Camcevi ETM[®]) are gonadotropin-releasing hormone (GnRH) receptor agonists.

FDA Approved Indication(s)

Leuprolide acetate is indicated for:

- Palliative treatment of advanced prostate cancer:
 - Leuprolide acetate injection
- Treatment of advanced prostate cancer:
 - Lupron Depot (7.5, 22.5, 30, 45)
 - Eligard
 - Vabrinty
- Management of endometriosis, including pain relief and reduction of endometriotic lesions; In combination with a norethindrone acetate for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms:

○ Lupron Depot (3.75, 11.25)
Limitation(s) of use: total duration of therapy plus add-back therapy should not exceed 12 months due to concerns about adverse impact on bone mineral density

- Concomitant use with iron therapy for preoperative hematologic improvement of women with anemia caused by uterine leiomyomata [fibroids] for whom three months of hormonal suppression is deemed necessary:

○ Lupron Depot (3.75, 11.25)

Limitation of use: not indicated for combination use with norethindrone acetate add-back therapy for the preoperative hematologic improvement of women with anemia caused by heavy menstrual bleeding due to fibroids

- Treatment of children with central precocious puberty (CPP):
 - Fensolvi
 - Leuprolide acetate
 - Lupron Depot-Ped (7.5, 11.25, 15, 30, 45)

Camcevi and Camcevi ETM are indicated for the treatment of adult patients with 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 leuprolide acetate, Camcevi, Camcevi ETM, Eligard, Fensolvi, Lupron Depot, Lupron Depot-Ped, and Vabrinty 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 one of the following (a, b, c, d, or e):
 - a. Leuprolide acetate injection;
 - b. Camcevi/Camcevi ETM;
 - c. Eligard;
 - d. Lupron Depot;
 - e. Vabrinty;
3. Prescribed by or in consultation with an oncologist or urologist;
4. Age \geq 18 years;
5. Request meets one of the following (a, b, c, or d):*
 - a. Leuprolide acetate injection (SC): Dose does not exceed 1 mg per day;
 - b. Camcevi/Camcevi ETM (SC): Dose does not exceed 21 mg per 3 months or 42 mg per 6 months;
 - c. Eligard (SC), Lupron Depot (IM), or Vabrinty (SC): Dose does not exceed 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, 45 mg per 6 months;
 - d. 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:

HIM – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

B. Endometriosis (must meet all):

1. Diagnosis of endometriosis;
2. Request is for Lupron Depot (3.75 mg, 11.25 mg);
3. Prescribed by or in consultation with a gynecologist;
4. One of the following (a or b):
 - a. Age \geq 18 years;
 - b. Age $<$ 18 years and member is postpubertal (request is following puberty);
5. Endometriosis as a cause of pain is one of the following (a or b):
 - a. Surgically confirmed;
 - b. Both of the following (i and ii):
 - i. Clinically suspected;

- ii. Failure of a 3-month trial of one of the following within the last year, unless clinically adverse effects are experienced or all are contraindicated (1, 2, or 3):*

**For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

- 1) A nonsteroidal anti-inflammatory drug (*see Appendix B for examples*);
 - 2) An oral or injectable depot contraceptive (*see Appendix B for examples*);
 - 3) A progestin (*see Appendix B for examples*);
6. For members currently receiving treatment with leuprolide, total duration of therapy has not exceeded 12 months;
 7. Dose does not exceed 3.75 mg per month or 11.25 mg per 3 months.

Approval duration:

HIM – 6 months

Commercial – 6 months or to member's renewal date, whichever is longer

C. Uterine Fibroids (must meet all):

1. Diagnosis of anemia secondary to uterine leiomyomata (fibroids);
2. Diagnosis is confirmed by ultrasound;
3. Request is for Lupron Depot (3.75 mg, 11.25 mg);
4. Prescribed by or in consultation with gynecologist;
5. One of the following (a or b):
 - a. Age \geq 18 years;
 - b. Age < 18 years and member is postpubertal (request is following puberty);
6. Lupron Depot is prescribed concurrently with iron therapy;
7. Prescribed preoperatively to reduce fibroid size and improve hematologic control;
8. For members currently receiving treatment with leuprolide, total duration of therapy has not exceeded 3 months per treatment course;
9. Dose does not exceed 3.75 mg per month or 11.25 mg per 3 months.

Approval duration: 3 months

D. Central Precocious Puberty (must meet all):

1. Member meets one of the following (a or b):
 - a. Diagnosis of CPP confirmed by all of the following (i, ii, and iii):
 - i. Elevated basal luteinizing hormone (LH) level > 0.2 - 0.3 mIU/mL (dependent on type of assay used) and/or elevated leuprolide-stimulated LH level > 3.3 - 5 IU/L (dependent on type of assay used);
 - ii. Difference between bone age and chronological age was > 1 year (bone age-chronological age);
 - iii. Age at onset of secondary sex characteristics (1 or 2):
 - 1) Female: < 8 years;
 - 2) Male: < 9 years;
 - b. Request is for diagnostic use;
2. Request is for one of the following (a, b, or c):
 - a. Fensolvi;
 - b. Leuprolide acetate;
 - c. Lupron Depot-Ped: 7.5 mg, 11.25 mg, 15 mg, 30 mg, 45 mg;

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 - 11 years;
 - b. Male: 2 - 12 years;
5. Dose does not exceed the following (a, b, c, or d):
 - a. Diagnostic use: Leuprolide acetate: 20 mcg/kg or as needed;
 - b. Therapeutic use: Fensolvi: 45 mg per 6 months;
 - c. Therapeutic use: Leuprolide acetate (SC): Initial: 50 mcg/kg per day; titrate dose upward by 10 mcg/kg per day if down-regulation is not achieved (higher mg/kg doses may be required in younger children);
 - d. Therapeutic use: Lupron Depot-Ped (IM): 15 mg per month (1-month formulation), 30 mg per 3 months (3-month formulation) or 45 mg per 6 months (6-month formulation) (dosing is weight-based for a 1-month and a 3-month formulations).

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

E. Breast and Ovarian Cancer (off-label) (must meet all):

1. Diagnosis of hormone receptor-positive breast cancer or ovarian cancer (including fallopian tube and primary peritoneal cancer, malignant sex cord-stromal tumors, carcinosarcoma (malignant mixed Müllerian tumors), low-grade serous carcinoma, endometrioid carcinoma, mucinous neoplasms of the ovary);
2. Request is for one of the following (a, b, or c):
 - a. Lupron Depot;
 - b. Eligard for breast cancer;
 - c. Vabrinty;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years;
5. Request meets one of the following (a, b, or c):*
 - a. Lupron Depot: Dose does not exceed 3.75 mg per month, 7.5 mg per month, 11.25 mg per 3 months, or 22.5 mg per 3 months;
 - b. Eligard or Vabrinty: Dose does not exceed 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, 45 mg per 6 months;
 - c. 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:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

F. Gender Dysphoria, Gender Transition (off-label) (must meet all):

1. For HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN;

2. Diagnosis of gender dysphoria or request is for gender transition;
3. Prescribed by or in consultation with both of the following (a and b):
 - a. An endocrinologist;
 - b. A provider with expertise in gender dysphoria and transgender medicine based on a certified training program or affiliation with local transgender health services (e.g., mental health professional such as psychologist, psychiatrist, see *Appendix D*);
4. Age and pubertal development - meets one of the following (a or b):
 - a. Member is < 18 years of age and has reached or passed through Tanner Stage 2*;
**Age ranges approximating Tanner Stage 2 pubertal development extend from 8 to 13 years of age in girls and 9 to 14 years of age in boys.*
 - b. Member is ≥ 18 years of age and has failed to achieve physiologic hormone levels with gender-affirming hormonal therapy (e.g., estrogen, testosterone) unless contraindicated or clinically significant adverse effects are experienced;
5. Member demonstrates understanding of expected GnRH analogue treatment outcomes and has given consent for such treatment;
6. If member has a psychiatric comorbidity, member is followed by mental health provider;
7. Psychosocial support will be provided during treatment;
8. Provider attestation of understanding current State regulations regarding transgender-related health care and such care is coverable under the State regulations (see *Appendix D*);
9. Dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

G. Salivary Gland Tumors (off-label) (must meet all):

1. Diagnosis of salivary gland tumors;
2. Disease is androgen receptor positive and recurrent, unresectable, or metastatic;
3. Prescribed by or in consultation with an oncologist;
4. Request is for one of the following (a, b, c, or d):
 - a. Eligard;
 - b. Lupron Depot;
 - c. Camcevi/Camcevi ETM;
 - d. Vabrinty;
5. Dose is within FDA maximum limit for any FDA-approved indication (see Section V) or 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:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

H. Uterine Sarcoma (off-label) (must meet all):

1. Diagnosis of uterine sarcoma;
2. Request is for Lupron Depot;
3. Prescribed by or in consultation with an oncologist;
4. Member has endometrial stromal sarcoma or adenosarcoma without sarcomatous overgrowth;
5. Member is premenopausal;
6. Prescribed in combination with anastrozole, letrozole or exemestane;
7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 3.75 mg per month or 11.25 mg per 3 months;
 - 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:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

I. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and HIM.PA.33 for health insurance marketplace; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial and HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Prostate Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving leuprolide acetate injection, Camcevi/Camcevi ETM, Eligard, or Lupron Depot for prostate cancer and has received this medication for at least 30 days;
2. Request is for one of the following (a, b, c, d, or e):
 - a. Leuprolide acetate injection;
 - b. Camcevi/Camcevi ETM;
 - c. Eligard;
 - d. Lupron Depot;

- e. Vabrinty;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a, b, c, or d):*
 - a. Leuprolide acetate injection (SC): New dose does not exceed 1 mg per day;
 - b. Camcevi/Camcevi ETM (SC): New dose does not exceed 21 mg per 3 months or 42 mg per 6 months;
 - c. Eligard (SC), Lupron Depot (IM), or Vabrinty (SC): New dose does not exceed 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, 45 mg per 6 months;
 - d. 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:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

B. Endometriosis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Request is for Lupron Depot (3.75 mg, 11.25 mg);
3. Member is responding positively to therapy as evidenced by improvement in any of the following parameters, including but not limited to: dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, or size of endometrial lesions;
4. Total duration of leuprolide therapy has not exceeded 12 months;
5. If request is for a dose increase, new dose does not exceed 3.75 mg per month or 11.25 mg per 3 months.

Approval duration:

HIM – up to a total treatment duration of 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

C. Uterine Fibroids:

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

D. Central Precocious Puberty (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);

2. Request is for one of the following (a, b, or c):
 - a. Fensolvi;
 - b. Leuprolide acetate;
 - c. Lupron Depot-Ped: 7.5 mg, 11.25 mg, 15 mg, 30 mg, 45 mg;
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 one of the following (a, b, or c):
 - a. Leuprolide acetate (SC): Initial: 50 mcg/kg per day; titrate dose upward by 10 mcg/kg per day if down-regulation is not achieved (higher mg/kg doses may be required in younger children);
 - b. Lupron Depot-Ped (IM): 15 mg per month (1-month formulation), 30 mg per 3 months (3-month formulation) or 45 mg per 6 months (6-month formulation) (dosing is weight-based for a 1-month and a 3-month formulations);
 - c. Fensolvi: 45 mg per 6 months.

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

E. Breast and Ovarian Cancer (off-label) (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Lupron Depot or Eligard for hormone receptor-positive breast cancer or ovarian cancer and has received this medication for at least 30 days;
2. Request is for one of the following (a, b, or c):
 - a. Lupron Depot;
 - b. Eligard for breast cancer;
 - c. Vabrinty;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
 - a. Lupron Depot: New dose does not exceed 3.75 mg per month, 7.5 mg per month, 11.25 mg per 3 months, or 22.5 mg per 3 months;
 - b. Eligard or Vabrinty: New dose does not exceed 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, 45 mg per 6 months;
 - c. 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:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

F. Gender Dysphoria, Gender Transition (off-label) (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy (e.g., member continues to meet their individual goals of therapy for gender dysphoria);
3. For HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN;
4. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

G. Salivary Gland Tumors (off-label) (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Eligard, Lupron Depot, or Camcevi/Camcevi ETM for salivary gland tumors and has received this medication for at least 30 days;
2. Request is for one of the following (a, b, c, or d):
 - a. Eligard;
 - b. Lupron Depot;
 - c. Camcevi/Camcevi ETM;
 - d. Vabrinty;
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

H. Uterine Sarcoma (off-label) (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Lupron Depot for uterine sarcoma and has received this medication for at least 30 days;
2. Request is for Lupron Depot;
3. Member is responding positively to therapy;

4. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication (see Section V) or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:

HIM – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

I. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and HIM.PA.33 for health insurance marketplace; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial and HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

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 – CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CPP: central precocious puberty

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th edition

FDA: Food and Drug Administration

GnRH: gonadotropin-releasing hormone

LH: luteinizing hormone

NCCN: National Comprehensive Cancer Network

WPATH: World Professional Association for Transgender Health

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
NSAIDs*: ibuprofen, naproxen, fenoprofen, ketoprofen, mefenamic acid, meclofenamate, indomethacin, tolmetin, diclofenac, etodolac, diflunisal, meloxicam, piroxicam	Endometriosis Varies – refer to specific prescribing information	Varies – refer to specific prescribing information
Combined oral estrogen-progesterone contraceptives: ethinyl estradiol + (desogestrel, ethynodiol diacetate, drospirenone, etonogestrel, levonorgestrel, norelgestromin, norethindrone, norgestimate, or norgestrel); estradiol valerate + dienogest; mestranol + norethindrone	Endometriosis 1 tablet PO QD (may vary per specific prescribing information)	1 tablet per day (may vary per specific prescribing information)
Progestin-only oral contraceptives: norethindrone	Endometriosis 0.35 mg PO QD	0.35 mg per day
Progestin-only oral contraceptives: Slynd [®] (drospirenone)	Endometriosis 1 tablet PO QD	1 tablet PO QD
Depot injection progestin contraceptives: medroxyprogesterone acetate	Endometriosis IM: 150 mg per 3 months (every 13 weeks) SC: 104 mg per 3 months (every 12 to 14 weeks)	See regimen

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Examples provided may not be all-inclusive*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Known hypersensitivity to GnRH, GnRH agonist analogs, or any of the components of the individual products (all leuprolide products);
 - Pregnancy (all leuprolide products except Camcevi/Camcevi ETM, Eligard);
 - Lupron Depot 3.75 mg/11.25 mg:
 - Undiagnosed abnormal vaginal bleeding;
 - Breast-feeding;
 - If used with norethindrone acetate:
 - Thrombophlebitis, thromboembolic disorders, cerebral apoplexy, or a past history of these conditions;
 - Markedly impaired liver function or liver disease;
 - Known or suspected carcinoma of the breast.
- Boxed warning(s): None reported

Appendix D: General Information

- World Professional Association for Transgender Health (WPATH) offers their Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care. Additionally, the following link provides a search tool to locate WPATH member providers: <https://app.wpath.org/provider/search>
- Transgender Care Therapy Certification Training is also offered by the International Transgender Certification Association (ITCA). Professionals with expertise in transgender care can be located using the following search tool: <https://transgendercertification.com/locate-a-professional/>
- The WPATH Standards of Care Version 8 recommend that adolescents are managed by a multidisciplinary care team that involves both medical and mental health professionals. The list of key disciplines includes but is not limited to: adolescent medicine/primary care, endocrinology, psychology, psychiatry, speech/language pathology, fertility, social work, support staff, and the surgical team. The need to include a healthcare professional with some expertise in mental health does not dictate the inclusion of a psychologist, psychiatrist or social work in every assessment. Instead, a general medical practitioner, nurse or other qualified health care professional could also fulfill this requirement if they have sufficient expertise to diagnose gender incongruence, recognize mental health concerns, distinguish between these concerns and gender dysphoria, incongruence, and diversity, assist a transgender person in care planning and preparing for gender affirmative medical and surgical treatments, and refer to a mental health professional if needed.
- The Movement Advancement Project can be referenced to confirm transgender-related health care is coverable under the State regulations. This can be accessed at: https://www.lgbtmap.org/equality-maps/healthcare/youth_medical_care_bans

Appendix E: Additional Information on Diagnosis-specific HCPCS Codes, Billable Units, and Day Supply

Diagnosis	Requested Product	HCPCS Code	Billable Units	Day Supply
Prostate Cancer	Leuprolide acetate, per 1 mg	J9218	14	14
	Lupron Depot 1-Month & Eligard 7.5 mg	J9217	1	28
	Lupron Depot 3-Month & Eligard 22.5 mg		3	84
	Lupron Depot 4-Month & Eligard 30 mg		4	112
	Lupron Depot 6-Month & Eligard 45 mg		6	168
	Camcevi 6-Month 42 mg	J1952	42	168
	Camcevi ETM 3-Month 21 mg	J1952	21	84
Endometriosis, Uterine Fibroids	Lupron Depot 1-Month 3.75 mg	J1950	1	28
	Lupron Depot 3-Month 11.25 mg		3	84
	Leuprolide acetate, per 1 mg	J9218	14	14
	Lupron Depot-Ped 7.5 mg	J1950	2	28

Diagnosis	Requested Product	HCPCS Code	Billable Units	Day Supply
Central Precocious Puberty	Lupron Depot-Ped 11.25 mg		3	28
	Lupron Depot-Ped 15 mg		4	28
	Lupron Depot-Ped 30 mg		8	84
	Lupron Depot-Ped 45 mg		12	168
	Fensolvi 45 mg kit		J1951	12
Breast Cancer	Lupron Depot 1-Month 3.75 mg	J1950	1	28
	Lupron Depot 3-Month 11.25 mg		3	84
	Lupron Depot 1-Month & Eligard 7.5 mg	J9217	1	28
	Lupron Depot 3-Month & Eligard 22.5 mg		3	84
	Eligard 4-month 30 mg		4	112
	Eligard 6-month 45 mg		6	168
Ovarian Cancer	Lupron Depot 1-Month 3.75 mg	J1950	1	28
	Lupron Depot 3-Month 11.25 mg		3	84
Salivary Gland Tumors	Lupron Depot 1-Month & Eligard 7.5 mg	J9217	1	28
	Lupron Depot 3-Month & Eligard 22.5 mg		3	84
	Camcevi 6-Month 42 mg	J1952	42	168
	Camcevi ETM 3-Month 21 mg	J1952	21	84

NA – not available

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Leuprolide acetate injection	Prostate cancer	Camcevi (SC) – 42 mg every 6 months	See regimen
Leuprolide acetate (Lupron Depot 7.5, 22.5, 30, 45)		Camcevi ETM (SC) – 21 mg every 3 months	See regimen
		Leuprolide acetate injection (SC): 1 mg per day	See regimen
Leuprolide acetate (Eligard 7.5, 22.5, 30, 45)		Lupron Depot (IM) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	See regimen
		Eligard (SC) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	See regimen
Leuprolide mesylate (Camcevi, Camcevi ETM)		Vabrinty (SC) – 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	See regimen

Drug Name	Indication	Dosing Regimen	Maximum Dose
Leuprolide acetate (Lupron Depot 3.75, 11.25)	Endometriosis	Lupron Depot - 3.75 mg per month; 11.25 mg per 3 months	See regimen
Leuprolide acetate (Lupron Depot 3.75)	Uterine fibroids	Lupron Depot (IM) - 3.75 mg/month, 11.25 mg per 3 months	See regimen
Leuprolide acetate injection	CPP	Leuprolide acetate (SC): <ul style="list-style-type: none"> • Diagnostic: 20 mcg/kg or as needed; • Treatment: Initial: 50 mcg/kg/day; titrate dose upward by 10 mcg/kg/day if down-regulation is not achieved (higher mg/kg doses may be required in younger children). 	See regimen
Leuprolide acetate (Lupron Depot-Ped 7.5, 11.25, 15 [1 mo]; 11.25, 30 [3 mo]); 45 [6 mo]		Lupron Depot-Ped (IM): Monthly administration weight-based starting dose: 7.5 mg (\leq 25 kg), 11.25 mg ($>$ 25 to 37.5 kg), 15 mg ($>$ 37.5 kg) (increase as needed up to 15 mg/month); 3-month administration: 11.25 mg or 30 mg; 6-month administration: 45 mg	See regimen
Fensolvi (leuprolide acetate)		Fensolvi (SC): 45 mg once every six months	See regimen
Leuprolide acetate (Lupron Depot 3.75)	Breast cancer (off-label)	Lupron Depot (IM) 3.75 mg per month, 11.25 mg per 3 months	See regimen
Leuprolide acetate (Eligard 7.5, 22.5, 30, 45)		Eligard (SC) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months Vabrinty (SC) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	
Leuprolide acetate (Lupron Depot 3.75, 11.25)	Ovarian cancer (off-label)	Lupron Depot (IM) 3.75 mg per month, 11.25 mg per 3 months	See regimen

Drug Name	Indication	Dosing Regimen	Maximum Dose
Leuprolide acetate (Lupron Depot 7.5, 22.5)	Salivary gland tumors (off-label)	Lupron Depot (IM) - 7.5 mg per month; 22.5 mg per 3 months.	See regimen
Leuprolide acetate (Eligard 7.5, 22.5, 30, 45)		Eligard (SC) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	
Leuprolide mesylate (Camcevi, Camcevi ETM)		Camcevi (SC) – 42 mg every 6 months	
		Camcevi ETM (SC) – 21 mg every 3 months	
		Vabrinty (SC) - 7.5 mg per month; 22.5 mg per 3 months; 30 mg per 4 months; 45 mg per 6 months	

VI. Product Availability

Drug Name	Availability
Leuprolide acetate injection	Kit: 2.8 mL multi-dose vial (1 mg/0.2 mL)
Leuprolide acetate (Eligard)	Kit: 7.5 mg (1 month), 22.5 mg (3 month), 30 mg (4 month), 45 mg (6 month)
Leuprolide acetate (Lupron Depot)	Prefilled syringe: 7.5 mg (1 month), 22.5 mg (3 month), 30 mg (4 month), 45 mg (6 month)
Leuprolide acetate (Lupron Depot 3.75)	Prefilled syringe: 3.75 mg (1 month)
Leuprolide acetate (Lupron Depot 11.25)	Prefilled syringe: 11.25 mg (3 month)
Leuprolide acetate (Lupron Depot-Ped)	Prefilled syringe: 7.5 mg (1 month), 11.25 mg (1 month), 15 mg (1 month) Prefilled syringe: 11.25 mg (3 month), 30 mg (3 month) Prefilled syringe: 45 mg (6 month)
Leuprolide acetate (Fensolvi)	Kit: syringe A: prefilled with diluent for reconstitution and syringe B: prefilled with 45 mg lyophilized leuprolide acetate powder
Leuprolide acetate (Vabrinty)	Kit: 7.5 mg (1 month), 22.5 mg (3 month), 30 mg (4 month), 45 mg (6 month)
Leuprolide mesylate (Camcevi)	Injection emulsion: 42 mg
Leuprolide mesylate (Camcevi ETM)	Injection emulsion: 21 mg

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Gender Dysphoria

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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
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J1951	Injection, leuprolide acetate for depot suspension (Fensolvi), 0.25 mg
J1952	Leuprolide injectable, Camcevi, 1 mg
J1954	Injection, leuprolide acetate for depot suspension (Cipla), 7.5 mg
J9003	Leuprolide injectable (camcevi etm), 1 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219	Leuprolide acetate implant, 65 mg

*See Appendix E: Additional Information on Diagnosis-specific HCPCS Codes, Billable Units, and Day Supply

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created (adapted from CP.PHAR.173) per September SDC and prior clinical guidance.	09.25.24	11.24
For gender dysphoria and gender transition, added requirement for provider attestation of understanding current State regulations regarding transgender-related health care and such care is coverable under the State regulations, added to Appendix D link and notation that the Movement Advancement Project can be referenced to	02.12.25	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
confirm transgender-related health care is coverable under the State regulations.		
4Q 2025 annual review: per NCCN for ovarian cancer added supported uses in malignant sex cord-stromal tumors, carcinosarcoma (malignant mixed Müllerian tumors), low-grade serous carcinoma, endometrioid carcinoma, mucinous neoplasms of the ovary; added Eligard as a product that can be used for breast cancer; added Camcevi as a product that can be used for salivary gland tumors; added criteria set for uterine sarcoma; for endometriosis and uterine leiomyomata (fibroids), added allowance for age < 18 years when member is postpubertal per prescribing information; added step therapy bypass for IL HIM per IL HB 5395; RT4: added new strength, Camcevi ETM (21 mg); references reviewed and updated.	09.10.25	11.25
Added Vabrinty to policy per SDC request.	12.18.25	02.26
For gender dysphoria and gender transition, as a result of the Marketplace Integrity and Affordability rule, added requirement for HIM, request is for a member in a state other than the following, where gender dysphoria and gender transition treatment is not a covered benefit: AL, AZ, AR, FL, GA, IN, IA, KS, KY, LA, MS, MO, NE, NH, NC, OH, OK, SC, and TN. HCPCS code added [J9003].	02.24.26	

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.

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