

Reference number(s)
1918-A

SPECIALTY GUIDELINE MANAGEMENT

ZOLADEX (goserelin acetate)

POLICY

I. INDICATIONS

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 Indications

1. Prostate cancer
 - a. For use in combination with flutamide for the management of locally confined stage T2b-T4 (Stage B2-C) carcinoma of the prostate. Treatment with Zoladex and flutamide should start 8 weeks prior to initiating radiation therapy and continue during radiation therapy.
 - b. In the palliative treatment of advanced carcinoma of the prostate
2. Endometriosis
For the management of endometriosis, including pain relief and reduction of endometriotic lesions for the duration of therapy. Experience with Zoladex for the management of endometriosis has been limited to women 18 years of age and older treated for 6 months (Zoladex 3.6 mg strength only)
3. Endometrial thinning
For use as an endometrial-thinning agent prior to endometrial ablation for dysfunctional uterine bleeding (Zoladex 3.6 mg strength only)
4. Advanced breast cancer
For use in the palliative treatment of advanced breast cancer in pre-and perimenopausal women

B. Compendial Uses

1. Breast cancer
2. Prostate cancer
3. Gender dysphoria (also known as gender non-conforming or transgender persons)
4. Preservation of ovarian function
5. Prevention of recurrent menstrual related attacks in acute porphyria
6. Uterine leiomyomata (fibroids)
7. Treatment of chronic anovulatory uterine bleeding with severe anemia

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

II. EXCLUSIONS

Coverage will not be provided for members with any of the following exclusions: Use of the 10.8 mg strength for diagnoses other than prostate cancer, breast cancer, and gender dysphoria.

III. DOCUMENTATION

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Submission of the following information is necessary to initiate the prior authorization review: Hormone receptor status testing results (where applicable).

IV. PRESCRIBER SPECIALTIES

For gender dysphoria, the medication must be prescribed by or in consultation with a pediatric endocrinologist that has collaborated care with a mental health care provider for members less than 18 years of age.

V. CRITERIA FOR INITIAL APPROVAL

A. Breast Cancer

Authorization of 12 months may be granted for the treatment of hormone receptor-positive breast cancer.

B. Prostate Cancer

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

C. Endometriosis

Authorization of a total of 6 months may be granted to members for treatment of endometriosis.

D. Endometrial-thinning agent

1. Authorization of 2 doses may be granted for endometrial thinning prior to endometrial ablation or resection for dysfunctional uterine bleeding.
2. Authorization of a total of 6 months may be granted for treatment of chronic anovulatory uterine bleeding with severe anemia.

E. Gender Dysphoria

1. Authorization of 12 months may be granted for pubertal hormonal suppression in an adolescent member when all of the following criteria are met:
 - a. The member has a diagnosis of gender dysphoria.
 - b. The member has reached Tanner stage 2 of puberty or greater.
 - c. The member's comorbid conditions are reasonably controlled.
 - d. The member has been educated on any contraindications and side effects to therapy.
 - e. The member has been informed of fertility preservation options.
2. Authorization of 12 months may be granted for gender transition when all of the following criteria are met:
 - a. The member has a diagnosis of gender dysphoria.
 - b. The member will receive Zoladex concomitantly with gender-affirming hormones.
 - c. The member's comorbid conditions are reasonably controlled.
 - d. The member has been educated on any contraindications and side effects to therapy.
 - e. The member has been informed of fertility preservation options.

F. Preservation of ovarian function

Authorization of 3 months may be granted for preservation of ovarian function when the member is premenopausal and undergoing chemotherapy.

G. Prevention of recurrent menstrual related attacks in acute porphyria

Authorization of 12 months may be granted for prevention of recurrent menstrual related attacks in members with acute porphyria when the requested medication is prescribed by or in consultation with a physician experienced in the management of porphyrias.

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H. Uterine leiomyomata (fibroids)

Authorization of a total of 3 months may be granted for treatment of uterine leiomyomata (fibroids) prior to surgery.

VI. CONTINUATION OF THERAPY

A. Breast cancer

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

B. Prostate cancer

Authorization of 12 months may be granted for continued treatment 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.

C. All members (including new members) requesting authorization for continuation of therapy for the specified indications below must meet all initial authorization criteria:

1. Endometriosis
2. Endometrial-thinning agent
3. Gender dysphoria
4. Preservation of ovarian function
5. Prevention of recurrent menstrual related attacks in acute porphyria
6. Uterine leiomyomata (fibroids)

VII. REFERENCES

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