

<b>Clinical Policy Title:</b>	degarelix acetate
<b>Policy Number:</b>	RxA.129
<b>Drug(s) Applied:</b>	Firmagon®
<b>Original Policy Date:</b>	02/07/2020
<b>Last Review Date:</b>	08/28/2024
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Prostate Cancer (must meet all):

1. Diagnosis of advanced prostate cancer.

#### Approval duration

**All Lines of Business (except Medicare): 6 months**

### II. Continued Therapy Approval

#### A. Prostate Cancer (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval duration

**All Lines of Business (except Medicare): 12 months**

## References

1. National Comprehensive Cancer Network. Prostate cancer Version 4.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/prostate.pdf](https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf). Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. References updated.	04/2020	05/06/2020
Policy was reviewed: 1. Policy title table updated. 2. Approval duration section updated to specify commercial and Medicaid plans. 3. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance...". 4. References updated.	01/22/2021	03/09/2021
Policy was reviewed:	11/25/2021	1/17/2022

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<ol style="list-style-type: none"> <li>1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".</li> <li>2. References were reviewed and updated.</li> </ol>		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. References were reviewed and updated.</li> </ol>	10/13/2022	01/17/2023
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed age restrictions.</li> <li>2. Removed prescriber restrictions.</li> <li>3. Removed dose restrictions.</li> <li>4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</li> <li>5. Removed reauthorization requirement for positive response to therapy.</li> <li>6. Updated approval duration verbiage.</li> <li>7. References were reviewed and updated.</li> </ol>	08/28/2024	09/13/2024