

Aetna Medicare Part B Drug Step Criteria

Gonadotropin Releasing Hormone (GnRH) Analogues

Preferred product(s): Eligard (leuprolide acetate)

This criteria document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization. Step criteria are applied in addition to any applicable National Coverage Determination (NCD), Local Coverage Determination (LCD), and Aetna Medicare Part B Drug Criteria. [Find Aetna Medicare Part B Drug Criteria documents.](#)

This program applies to GnRH analogue products as specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude use of the preferred product and may be based on previous use of a product. The coverage review process will determine situations where a clinical exception can be made. This program applies to all Medicare members who are new to treatment with a targeted product.

For the indication(s) listed below (new starts only):

1. Advanced prostate cancer
2. Gender dysphoria
3. Recurrent androgen receptor positive salivary gland tumors

TABLE. GnRH analogues

Status	Product(s)
Preferred*	Eligard (leuprolide acetate) – no prior authorization required
Non-preferred (targeted)**	Lupron depot (leuprolide acetate depot) Trelstar (triptorelin pamoate) Zoladex (goserelin acetate)

*Preferred products do not require prior authorization

**Non-preferred products may not be indicated for all indications listed above

EXCEPTION CRITERIA

Coverage for the targeted product(s) is provided when the member meets one or more of the following criteria:

1. Member has received an authorized dose of the requested product in the past 365 days (does not include samples or doses administered without prior authorization)
2. Documented inadequate response to a trial of the preferred product (documentation required upon request)
3. Documented intolerable adverse event to the preferred product (documentation required upon request)



Reference number
1009-AMBST

4. The preferred product is contraindicated for the member
5. The request is for a medically necessary indication not listed above

REFERENCES

1. Lupron depot (leuprolide acetate for depot suspension) [prescribing information]. North Chicago, IL: AbbVie Inc.; December 2023.
2. Trelstar (triptorelin pamoate for injectable suspension) [prescribing information]. Wayne, PA: Verity Pharmaceuticals, Inc.; November 2023.
3. Zoladex (goserelin acetate implant) [prescribing information]. Lake Forest, IL: TerSera Therapeutics LLC; March 2023.
4. Eligard (leuprolide acetate) [prescribing information]. Fort Collins, CO: Tolmar Pharmaceuticals, Inc.; January 2024.

DOCUMENT HISTORY

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See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. The formulary may change at any time. You will receive notice when necessary.