

Policy: MBP 67.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Supprelin LA (histrelin acetate implant)

I. Policy:

Supprelin LA (histrelin acetate implant)

II. Purpose/Objective:

To provide a policy of coverage regarding Supprelin LA (histrelin acetate implant)

III. Responsibility:

- A. Medical Directors
- B. Medical Management
- C. Pharmacy Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than
3. the department requiring/authoring the policy.
4. Devised – the date the policy was implemented.
5. Revised – the date of every revision to the policy, including typographical and grammatical changes.
6. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) the service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age

DESCRIPTION:

Supprelin LA (histrelin acetate implant) is a gonadotropin releasing hormone (GnRH) agonist. The primary goal of all GnRH agonist therapy is to maintain constant levels of the drug in order to have continuous desensitization of GnRH receptors and thus complete hormonal inhibition.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Supprelin LA (histrelin acetate implant) will be considered medically necessary for Central Precocious Puberty when all of the following criteria are met:

- Medical record documentation of a diagnosis of central precocious puberty; **AND**
- Therapeutic failure on, intolerance to or contraindication to Lupron Depot – Ped

Supprelin LA (histrelin acetate implant) will be considered medically necessary for Gender Confirmation Treatment when all of the following criteria are met:

- Psychological evaluation for gender dysphoria by a behavioral health professional with a minimum of a master's degree or equivalent who is capable of evaluating the member in accordance with WPATH Guidelines:
 1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
 2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
 3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
 4. Documented supervised training and competence in psychotherapy or counseling.
 5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
 6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.
- The use of medical intervention for gender dysphoria is age dependent. For use of a gonadotropin-releasing hormone (GnRH) analogs, the member must be peri-pubertal and a minimum of Tanner Stage 2, as documented by the provider. GnRH analogs are not medically necessary once the individual is post-pubertal.

INFORMATIONAL ONLY:

- **Pre-pubertal** - no medical treatment
- **Peri-pubertal** – gonadotropin-releasing hormone (GnRH) analogs to achieve suppression of pubertal hormones may be considered once the member reaches Tanner Stage* 2

*The Tanner Scale is measurement of physical development in children, adolescents and adults.
http://www.childgrowthfoundation.org/CMS/FILES/Puberty_and_the_Tanner_Stages.pdf

Between 14 – 16 yrs of age –pubertal development of the desired opposite sex can be using a gradually increasing dose schedule of cross-gender hormone.

Adolescents should be treated with GnRH analogues, progestins (e.g., medroxyprogesterone) or other medications that block and/or neutralize testosterone, estrogens and progesterone secretion.

- **Post-pubertal** – continuous hormone replacement therapy

Female to male: IM testosterone or topical testosterone

Male to female: Anti-androgen therapy (e.g., Spironolactone, GnRH agonists, plus estrogen)

Age 40 yrs or older – estrogen cream, patch or injectable

LINE OF BUSINESS:

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

References:

World Professional Association for Transgender Health (WPATH). Medical Necessity Statement: WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide.

Murad, MH, Elamin, MB, Garcia, MZ, et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. Clin Endocrinol 2010;72:214-31.

Hembree WC, Cohen-Kettenis P, et al. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. September 2009, 94(9):3132–3154

Hembree WC; Management of juvenile gender dysphoria. Curr Opin Endocrinol Diabetes Obes. 2013 Dec;20(6):559-64.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/14/09

Revised: 6/5/17 (gender dysphoria)

Reviewed: 2/12; 1/14; 01/20/2015, 3/16, 3/30/17, 3/29/18, 2/28/19, 2/1/20, 1/19/21, 1/13/22