



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Eligard

Page: 1 of 2

Effective Date: 9/14/2023

Last Review Date: 6/13/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input checked="" type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Eligard under the patient's prescription drug benefit.

### Description:

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 Indication

Palliative treatment of advanced prostate cancer

B. Compendial Uses

1. Prostate cancer
2. Recurrent androgen receptor positive salivary gland tumors

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

### Applicable Drug List:

Eligard

### Policy/Guideline:

#### Criteria for Initial Approval:

**A. Prostate cancer**

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

**B. Salivary gland tumors**

Authorization of 12 months may be granted for treatment of recurrent salivary gland tumors as a single agent when the tumor is androgen receptor positive.

#### Continuation of Therapy:

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



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

**Approval Duration and Quantity Restrictions:**

**Approval:** 12 months

**References:**

1. Eligard [package insert]. Fort Collins, CO: Tolmar Pharmaceuticals; April 2019.
2. The NCCN Drugs & Biologics Compendium® © 2022 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed February 1, 2022.