



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Eligard - Vabrinty

Page: 1 of 4

Effective Date: 10/20/2025

Last Review Date: 9/29/2025

Applies to:  Illinois  New Jersey  Pennsylvania Kids  Kentucky PRMD

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Eligard and Vabrinty 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.

#### FDA-Approved Indication

- Treatment of advanced prostate cancer

#### Compendial Uses

- Prostate cancer
- Androgen receptor positive salivary gland tumors
- Breast cancer – ovarian suppression
- Gender dysphoria (also known as transgender and gender diverse [TGD] persons)

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

### Applicable Drug List:

#### **Preferred Agent:**

Eligard

#### **Non-Preferred Agent:**

Vabrinty

### Policy/Guideline:

#### **Prescriber Specialties**

For gender dysphoria, the medication must be prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider for members less than 18 years of age.



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Page: 2 of 4

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## Coverage Criteria

Requests for Vabrinty require that the member is unable to take Eligard for the given diagnosis due to a trial and inadequate treatment response, intolerance, or a contraindication. Documentation is required for approval.

### Prostate Cancer

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

### Gender Dysphoria

Authorization of 12 months may be granted for *pubertal hormonal suppression* in an adolescent member when ALL the following criteria are met:

- The member has a diagnosis of gender dysphoria.
- The member is able to make an informed decision to engage in treatment.
- The member has reached Tanner stage 2 of puberty or greater.
- The member's comorbid conditions are reasonably controlled.
- The member has been educated on any contraindications and side effects to therapy.
- The member has been informed of fertility preservation options.

Authorization of 12 months may be granted for *gender transition* when ALL the following criteria are met:

- The member has a diagnosis of gender dysphoria.
- The member is able to make an informed decision to engage in treatment.
- The member will receive the requested medication concomitantly with gender-affirming hormones.
- The member's comorbid conditions are reasonably controlled.
- The member has been educated on any contraindications and side effects to therapy.
- The member has been informed of fertility preservation options.

### Salivary gland tumor

Authorization of 12 months may be granted for treatment of recurrent, unresectable, or metastatic salivary gland tumor as a single agent or in combination with abiraterone and prednisone when the tumor is androgen receptor positive.

### Breast Cancer – Ovarian Suppression

Authorization of 12 months may be granted for ovarian suppression in premenopausal members with hormone receptor-positive breast cancer at higher risk for recurrence (e.g., young age, high-grade tumor, lymph-node involvement) when used in combination with endocrine therapy.



AETNA BETTER HEALTH®  
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Name:	Eligard - Vabrinty	Page:	3 of 4
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## Continuation of Therapy

### Salivary Gland Tumor

Authorization of 12 months may be granted for continued treatment of salivary gland tumor in members requesting reauthorization when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

### Prostate Cancer

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.

### Gender Dysphoria

Authorization of 12 months may be granted for *continued treatment for pubertal hormonal suppression* in adolescent members requesting reauthorization when ALL the following criteria are met:

- The member has a diagnosis of gender dysphoria.
- The member is able to make an informed decision to engage in treatment.
- The member has previously reached Tanner stage 2 of puberty or greater.
- The member's comorbid conditions are reasonably controlled.
- The member has been educated on any contraindications and side effects to therapy.
- Before the start of therapy, the member has been informed of fertility preservation options.

Authorization of 12 months may be granted for *continued treatment for gender transition* in members requesting reauthorization when ALL the following criteria are met:

- The member has a diagnosis of gender dysphoria.
- The member is able to make an informed decision to engage in treatment.
- The member will receive the requested medication concomitantly with gender-affirming hormones.
- The member's comorbid conditions are reasonably controlled.
- The member has been educated on any contraindications and side effects to therapy.
- Before the start of therapy, the member has been informed of fertility preservation options.

### Breast Cancer – Ovarian Suppression

Authorization of 12 months may be granted (up to 5 years total) for continued treatment in members requesting reauthorization who were premenopausal at diagnosis and are still undergoing treatment with endocrine therapy.

## Other

Per state regulatory guidelines around gender dysphoria, age restrictions may apply.



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Name: Eligard - Vabrinty

Page: 4 of 4

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### Approval Duration and Quantity Restrictions:

**Approval:** 12 months

**Quantity Level Limit:** Reference Formulary for drug specific quantity level limits

### References:

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