



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Fensolvi

Page: 1 of 4

Effective Date: 11/13/2023

Last Review Date: 9/2023

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

Fensolvi is indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty (CPP).

B. Compendial Use

Gender dysphoria (also known as gender non-conforming or transgender persons)

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

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

Applicable Drug List:

Fensolvi

Policy/Guideline:

Documentation:

Submission of the following information is necessary to initiate the prior authorization review: For central precocious puberty, laboratory report or medical record of a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.

Prescriber Specialty:

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 patients less than 18 years of age.

Criteria for Initial Approval:

A. Central precocious puberty (CPP)

1. Authorization of 12 months may be granted for treatment of CPP in a female member when all of the following criteria are met:



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Fensolvi

Page: 2 of 4

Effective Date: 11/13/2023

Last Review Date: 9/2023

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

- i. Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging (e.g., computed tomography [CT] scan, magnetic resonance imaging [MRI]).
 - ii. The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.
 - iii. The assessment of bone age versus chronological age supports the diagnosis of CPP.
 - iv. The member was less than 8 years of age at the onset of secondary sexual characteristics.
2. Authorization of 12 months may be granted for treatment of CPP in a male member when all of the following criteria are met:
 - i. Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging, (e.g., CT scan, MRI).
 - ii. The diagnosis of CPP has been confirmed by a pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay.
 - iii. The assessment of bone age versus chronological age supports the diagnosis of CPP.
 - iv. The member was less than 9 years of age at the onset of secondary sexual characteristics.

B. Gender dysphoria

1. Authorization of 12 months may be granted for pubertal hormonal suppression in an adolescent member when all of the following criteria are met:
 - i. The member has a diagnosis of gender dysphoria.
 - ii. The member is able to make an informed decision to engage in treatment.
 - iii. The member has reached Tanner stage 2 of puberty or greater.
 - iv. The member's comorbid conditions are reasonably controlled.
 - v. The member has been educated on any contraindications and side effects to therapy.
 - vi. The member has been informed of fertility preservation options.
2. Authorization of 12 months may be granted for gender transition when all of the following criteria are met:
 - i. The member has a diagnosis of gender dysphoria.
 - ii. The member is able to make an informed decision to engage in treatment.
 - iii. The member will receive Fensolvi concomitantly with gender-affirming hormones.
 - iv. The member's comorbid conditions are reasonably controlled.
 - v. The member has been educated on any contraindications and side effects to therapy.
 - vi. The member has been informed of fertility preservation options.



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Fensolvi

Page: 3 of 4

Effective Date: 11/13/2023

Last Review Date: 9/2023

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

Continuation of Therapy:

A. Central precocious puberty (CPP)

1. Authorization of up to 12 months may be granted for continuation of therapy for CPP in a female member if the member is currently less than 12 years of age and the member meets both of the following:
 - i. The member is currently receiving the requested medication through a paid pharmacy or medical benefit.
 - ii. The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement).
2. Authorization of up to 12 months may be granted for continuation of therapy for CPP in a male member if the member is currently less than 13 years of age and the member meets both of the following:
 - i. The member is currently receiving the requested medication through a paid pharmacy or medical benefit.
 - ii. The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement).

B. Gender dysphoria

1. Authorization of 12 months may be granted for continued treatment for pubertal hormonal suppression in adolescent members requesting reauthorization when all of the following criteria are met:
 - i. The member has a diagnosis of gender dysphoria.
 - ii. The member is able to make an informed decision to engage in treatment.
 - iii. The member has previously reached Tanner stage 2 of puberty or greater.
 - iv. The member's comorbid conditions are reasonably controlled.
 - v. The member has been educated on any contraindications and side effects to therapy.
 - vi. Before the start of therapy, the member has been informed of fertility preservation options.
2. Authorization of 12 months may be granted for continued treatment for gender transition in members requesting reauthorization when all of the following criteria are met:
 - i. The member has a diagnosis of gender dysphoria.
 - ii. The member is able to make an informed decision to engage in treatment.
 - iii. The member will receive Fensolvi concomitantly with gender-affirming hormones.
 - iv. The member's comorbid conditions are reasonably controlled.



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Fensolvi Page: 4 of 4

Effective Date: 11/13/2023 Last Review Date: 9/2023

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

- v. The member has been educated on any contraindications and side effects to therapy.
- vi. Before the start of therapy, the member has been informed of fertility preservation options.

Approval Duration and Quantity Restrictions:

Approval: 12 months

References:

1. Fensolvi [package insert]. Fort Collins, CO: Tolmar, Inc.; April 2022.
2. Kletter GB, Klein KO, Wong YY. A pediatrician's guide to central precocious puberty. *Clin Pediatr*. 2015;54:414-424.
3. Carel J, Eugster EA, Rogol A, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123:e752-e762.
4. Bangalore Krishna K, Fuqua JS, Rogol AD, et al. Use of gonadotropin-releasing hormone analogs in children: Update by an international consortium. *Horm Res Paediatr*. 2019;91(6):357-372.
5. Houk CP, Kunselman AR, Lee PA. Adequacy of a single unstimulated luteinizing hormone level to diagnose central precocious puberty in girls. *Pediatrics*. 2009;123:e1059-e1063.
6. Kaplowitz P, Bloch C, the Section on Endocrinology. Evaluation and referral of children with signs of early puberty. *Pediatrics*. 2016;137:e20153732.
7. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
8. Gender Identity Research and Education Society. Guidance for GPs and other clinicians on the treatment of gender variant people. UK Department of Health. Published March 10, 2008.
9. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, 7th version. ©2012 World Professional Association for Transgender Health. Available at <http://www.wpath.org>.
10. Cheuiche AV, da Silveira LG, de Paula LCP, Lucena IRS, Silveiro SP. Diagnosis and management of precocious sexual maturation: an updated review. *Eur J Pediatr*. 2021;180(10):3073-3087.
11. Mahfouda S, Moore JK, Siafarikas A, et al. Puberty Suppression in Transgender Children and Adolescents. *Lancet Diabetes Endocrinol*. 2017; 5: 816-26.
12. Health Care for Transgender and Gender Diverse Individuals. ©2021 The American College of Obstetricians and Gynecologists. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals>.