



Horizon BCBSNJ  
Medical Necessity Guideline

**Section** Drugs  
**Policy Number**  
**Effective Date** 6/25/04  
**Review Date** 7/22/05, 3/28/08, 7/25/08, 5/12/09

**Subject:**  
**Ganirelix acetate**  
**Cetrotide (cetorelix acetate)**

**IMPORTANT NOTE:**

*The purpose of this policy is to provide general information applicable to the administration of outpatient prescription drug benefits that Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey, Inc. (collectively "Horizon BCBSNJ") insures or administers. **Outpatient prescription drugs are not covered under all Horizon benefit plans.** If the member's contract benefits differ from the pharmacy guideline, the contract prevails. Although a service, supply drug or procedure may be medically necessary, it may be subject to limitations and/or exclusions under a member's benefit plan. If a service, supply drug or procedure is not covered and the member proceeds to obtain the service, supply drug or procedure, the member may be responsible for the cost. Decisions regarding treatment and treatment plans are the responsibility of the physician. This policy is not intended to direct the course of clinical care a physician provides to a member, and it does not replace a physician's or pharmacist's independent professional clinical judgment or duty to exercise special knowledge and skill in the treatment of Horizon BCBSNJ members. Horizon BCBSNJ is not responsible for, does not provide, and does not hold itself out as a provider of medical care. The physician remains responsible for the quality and type of health care services provided to a Horizon BCBSNJ member.*

**Horizon BCBSNJ pharmacy guidelines do not constitute medical advice, authorization, certification, approval, explanation of benefits, offer of coverage, contract or guarantee of payment.**

**FDA-APPROVED INDICATION**

Infertility treatment for the inhibition of premature luteinizing hormone (LH) surges in women undergoing controlled ovarian hyperstimulation.

**Medical Necessity Guideline:**

1. The following questionnaire may be used to determine medical necessity of Antagon and Cetrotide prescriptions.

<b>CRITERIA FOR APPROVAL</b>		
1.	Does the patient have a diagnosis of infertility? [If the answer to this question is no, then no further questions]	Yes    No
2.	Is or will the patient be undergoing follicle stimulation as part of an Assisted Reproductive Technology (ART) program (i.e., in vitro fertilization -IVF, gamete intrafallopian transfer -GIFT, tubal embryo transfer-TET, zygote intrafallopian transfer -ZIFT)? [If the answer is yes, then please forward request to Horizon Pharmacy Service <a href="mailto:pharmacy_services@horizonblue.com">pharmacy_services@horizonblue.com</a> . When Horizon approves please proceed to question 6] [If the answer to this question is no, then skip to question 3.]	
3.	Will the patient be undergoing intrauterine insemination (IUI)?	Yes    No

[If the answer is no, then skip to question 5.]

- |    |  |     |    |
|----|--|-----|----|
| 4. | Is the patient < 45 years of age?<br>[If the answer is no, then please forward request to Horizon Pharmacy Service <a href="mailto:pharmacy_services@horizonblue.com">pharmacy_services@horizonblue.com</a> . When Horizon approves please proceed to question 6.]<br>[If the answer is yes, then skip to question 6.] | Yes | No |
| 5. | Is the patient undergoing controlled ovarian hyperstimulation without IUI or ART?<br>[If the answer to this question is no, then no further questions]   | Yes | No |
| 6. | Has it been determined that patient is <b>NOT</b> pregnant?<br>[If the answer to this question is no, then no further questions]   | Yes | No |
| 7. | Does the patient have any of the following contraindications: <ul style="list-style-type: none"> <li>• Hypersensitivity to extrinsic peptides, mannitol, GnRH or any other GnRH analogs</li> <li>• Known or suspected lactation</li> <li>• Severe renal impairment (for Cetrotide only)</li> </ul>                     | Yes | No |
| 8. | Is the request for more than the following dispensing limits?<br>Ganirelix – 5 injections every 30 days<br>Cetrotide 0.25 mg – 5 injections every 30 days<br>Cetrotide 3 mg – 1 kit every 30 days  | Yes | No |

### Guidelines for Approval

<b>Quantity Limits</b>		<b>Cetrotide 3 mg – 1 kit every 30 days</b> <b>Cetrotide 0.25 mg and Ganirelix – 5 injections every 30 days</b>			
<b>Duration of Approval</b>		<b>3 months</b>			
<b>Set 1 – IUI and patient &gt;= 45 years old– NEED HORIZON’S APPROVAL</b>		<b>Set 2 IUI - and patient &lt; 45 years old</b>		<b>Set 3 – ART – IVF – NEED HORIZON’S APPROVAL</b>	
<b>Yes to question(s)</b>	<b>No to question(s)</b>	<b>Yes to question(s)</b>	<b>No to question(s)</b>	<b>Yes to question(s)</b>	<b>No to question(s)</b>
1	2	1	2	1	7
3	4	3	7	2	8
6	7	4	8	6	
	8	6			
<b>Duration of Approval</b>					
	<b>12 Months</b>				
<b>Set 4 – COH w/out IUI or ART</b>					
<b>Yes to question(s)</b>	<b>No to question(s)</b>				
1	2				
5	3				
6	7				
	8				

**Horizon BCBSNJ Pharmacy Guideline Development Process:** This Horizon BCBSNJ Pharmacy Guideline (the “Pharmacy Guideline”) has been developed by Horizon BCBSNJ’s Pharmacy Drug Policy Subcommittee, Clinical Issues Subcommittee, and Quality Improvement Committee which include practicing physicians and pharmacists. This guideline is consistent with generally accepted standards of medical and pharmacy practice, and reflects Horizon BCBSNJ’s view of the subject health care services, supplies drugs or procedures, and in what circumstances they are deemed to be medically necessary or experimental/ investigational in nature. This Pharmacy Guideline also considers whether and to what degree the subject health care services, supplies or procedures are clinically appropriate, in terms of

type, frequency, extent, site and duration and if they are considered effective for the illnesses, injuries or diseases discussed. Where relevant, this Pharmacy Guideline considers whether the subject prescription drugs are being requested primarily for the convenience of the covered person or the health care provider. It may also consider whether the prescription drugs are more costly than alternative prescription drugs that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the relevant illness, injury or disease. In reaching its conclusion regarding what it considers to be the generally accepted standards of medical and pharmacy practice, Horizon BCBSNJ reviews and considers the following: all credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician and health care provider specialty society recommendations, the views of physicians and health care providers practicing in relevant clinical areas (including, but not limited to, the prevailing opinion within the appropriate specialty), the findings and directives of the Food and Drug Administration and any other relevant factor as determined by applicable State and Federal laws and regulations.

## **BLACK BOX WARNINGS**

None

## **RATIONALE**

The intent of the criteria is to follow selection elements noted in labeling.

Horizon BCBSNJ requested that all requests for patients undergoing an ART procedure – either a non-IUI procedure, or IUI and  $\geq 45$  years or age be sent to Horizon BCBSNJ services to verify whether the patient has coverage for this indication. If the patient qualifies for coverage, Horizon BCBSNJ will contact CVS Caremark to proceed with the clinical questions in the criteria. If the patient does not qualify for coverage, Horizon BCBSNJ will send a denial letter to the physician and inform CVS Caremark of this decision. Horizon BCBSNJ has requested a question addressing the following dosage limits: Ganirelix – 5 injections every 30 days; Cetrotide 0.25 mg – 5 injections every 30 days; Cetrotide 3 mg – 1 kit every 30 days.

## **ADDITIONAL INFORMATION**

Antagon and Cetrotide should be prescribed by physicians, who are experienced in infertility treatment. Before starting treatment with ganirelix acetate or cetrorelix acetate, exclude pregnancy.

### **Dosing and Administration:**

#### **Antagon**

After initiating FSH (follicle stimulating hormones) on day 2 or 3 of the cycle, Antagon injection 250  $\mu\text{g}$  may be administered subcutaneously once daily during the mid to late portion of the follicular phase. By taking advantage of endogenous pituitary FSH secretion, the requirement for exogenously administered FSH may be reduced. Treatment with Antagon should be continued daily until the day of hCG (chorionic gonadotropin) administration. When sufficient number of

follicles of adequate size are present, as assessed by ultrasound, final maturation of follicles is induced by the administration of hCG. The administration of hCG should be withheld in cases where the ovaries are abnormally enlarged on the last day of FSH therapy to reduce the change of developing ovarian hyperstimulation syndrome (OHSS).

#### **Cetrotide**

Ovarian stimulation with gonadotropins is started on cycle Day 2 or 3. The dose of gonadotropins should be adjusted according to individual response. Cetrotide may be administered subcutaneously as a single dose or multi-dose regimen. In the single dose regimen, a 3 mg dose of Cetrotide is administered once, when the serum estradiol level is indicative of an appropriate stimulation response, usually on stimulation day 7 of the early to mid follicular phase (range day 5-9). If hCG has not been administered within four days after injection of Cetrotide 3mg, Cetrotide 0.25mg should be administered once daily until the day of hCG administration.

In the multiple dose regimen, 0.25mg of Cetrotide is administered once daily on either stimulation day 5 (morning or evening) or day 6 (morning or evening) and continued once daily until the day of hCG administration.

When assessment by ultrasound shows a sufficient number of follicles of adequate size, hCG is administered to induce ovulation and final maturation of the oocytes. No hCG should be administered if the ovaries show an excessive response to the treatment with gonadotropins to reduce the chance of developing ovarian hyperstimulation syndrome (OHSS).

#### ***Storage:***

Antagon or Cetrotide 3mg should be stored at 25 degrees Centigrade (77 degrees Fahrenheit). Excursions are permitted

to 15 to 30 degrees Centigrade (59 to 86 degrees Fahrenheit).

Cetrotide 0.25mg should be stored in the refrigerator at 2 to 8 degrees Centigrade (36 to 46 degrees Fahrenheit).

### **CONTRAINDICATIONS/WARNINGS/PRECAUTIONS**

#### **Contraindications:**

- Known hypersensitivity to products or any of their components
- Known hypersensitivity to GnRH or any other GnRH analog
- Known or suspected pregnancy and lactation (Pregnancy Category X)

#### **Warnings:**

Antagon and Cetrotide should be prescribed by physicians who are experienced in infertility treatment. Before starting treatment, pregnancy must be excluded.

#### **Precautions:**

Antagon packaging contains natural rubber latex, which may cause allergic reactions.

Antagon and Cetrotide are not intended to be used in subjects aged 65 years and over.

### **REFERENCES**

1. Antagon® Product Information. Organon Inc. June 2001.
2. Cetrotide Product Information. Serono Inc. July 2002.

*Pharmacy Guidelines can be highly technical and are designed for use by the Horizon BCBSNJ professional staff in making coverage determinations. Members referring to this policy should discuss it with their treating physician or pharmacist, and should refer to their specific benefit plan for the terms, conditions, limitations and exclusions of their coverage.*

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