Leuprolide acetate (Eligard®, Vabrinty™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

INDICATIONS

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
- Salivary gland tumor
- 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.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review, where applicable, test results confirming:
- Androgen receptor (AR) positive status
- Hormone receptor (HR) positive status

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.

COVERAGE CRITERIA

Prostate Cancer

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

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.

Gender Dysphoria

*Individual is age 18 or older or the individual is less than age 18 as permissive under applicable law
Authorization of 12 months may be granted for pubertal hormonal suppression in an adolescent member who is seeking gender-affirming care when all of 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 in a member who is seeking gender-affirming care when all of 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.

CONTINUATION OF THERAPY

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.

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.

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.

Gender Dysphoria

*Individual is age 18 or older or the individual is less than age 18 as permissive under applicable law
Authorization of 12 months may be granted for continued treatment for pubertal hormonal suppression in an adolescent member who is seeking gender-affirming care and requesting reauthorization when all of 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 a member who is seeking gender-affirming care and requesting reauthorization when all of 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.

OTHER

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

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

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3. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed February 2, 2026.
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5. Coleman E, Radix AE, Brown GR, et al. Standards of care for the health of transgender and gender diverse people, version 8. 2022;23(Suppl 1):S1-S259.doi:10.1080/26895269.2022.2100644
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7. American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice; American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women. Health care for transgender and gender diverse individuals: ACOG Committee opinion, number 823. Obstet Gynecol. 2021;137(3):e75-e88.
8. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Breast Cancer. Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed February 2, 2026.

EFFECTIVE DATE 12/1/2026

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