Leuprolide Mesylate (Camcevi ETM™; Camcevi Kit)

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
Camcevi is indicated for the treatment of adult patients with advanced prostate cancer.

Compendial Uses
- Prostate Cancer
- Salivary Gland Tumor

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.

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.

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.

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

1. Camcevi [package insert]. Raleigh, NC: Accord BioPharma Inc.; September 2025.
2. Camcevi ETM [package insert]. Idron, France: Fareva Pau; August 2025.
3. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed January 30, 2026.

EFFECTIVE DATE 12/1/2026

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