SPECIALTY GUIDELINE MANAGEMENT

VANTAS (histrelin acetate)

POLICY

I. 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.

- A. <u>FDA-Approved Indication</u> Palliative treatment of advanced prostate cancer
- B. <u>Compendial Use</u> Prostate cancer

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

II. CRITERIA FOR INITIAL APPROVAL

Prostate cancer

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

III. CONTINUATION OF THERAPY

Prostate cancer

Authorization of 12 months may be granted for continued treatment 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.

IV. REFERENCES

- 1. Vantas [package insert]. Malvern, PA: Endo Pharmaceuticals; December 2020.
- 2. The NCCN Drugs & Biologics Compendium® © 2021 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed February 3, 2021.

Vantas opt-out 2086-A SGM P2021.docx

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