

Policy Name:	Zoladex (goserelin)	Policy #:	2804P
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Purpose of the Policy

The purpose of this policy is to define the criteria for coverage of Zoladex (goserelin).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Zoladex under the specialty medical benefit when the following criteria have been met.

Criteria

1. Coverage Criteria for Endometriosis

- 1.1 Diagnosis of endometriosis
- 1.2 Documentation member is not currently pregnant
- 1.3 Age 18 years or older
- 1.4 Ordered by or with an obstetrician-gynecologist (women's health doctor)
- 1.5 Failure to respond, intolerance, or contraindication to systemic contraceptive (birth control) and non-steroidal anti-inflammatory drugs (NSAIDs, such as ibuprofen, naproxen)
- 1.6 Documentation that member is not concurrently receiving therapy with Lupron, Synarel, or Orilissa
- 1.7 Approval Time: #6 implants over 6 months
 - Retreatment is not recommended because there is no safety data for retreatment available

2. Coverage Criteria for Endometrial Thinning

- 2.1 Documentation that member will be undergoing endometrial ablation for dysfunctional uterine bleeding
- 2.2 Approval Time: #2 implants over 6 months

3. Coverage Criteria for Oncology Indications

- 3.1 See the Pharmacy Oncology Regimen Review policy.

CPT Codes

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HCPCS Codes

J9202	Goserelin acetate implant, per 3.6 mg
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References

1. Zoladex 3.6 mg (goserelin) [prescribing information]. Deerfield, IL: TerSera Therapeutics LLC; March 2023.
2. Saridogan E, Tomassetti C, van Hanegem N, et al. ESHRE guideline: management of women with endometriosis. Hum Reprod Open. 2022 Feb 26;2022(2):hoac009.
3. Management of Endometriosis. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician Gynecologists. Number 114. 2010 (reaffirmed 2018). Obstet & Gynecol. 2010;116(1):223-236010.
4. Alkatout I, Mettler L, Beteta C, Hedderich J, et al. Combined surgical and hormone therapy for endometriosis is the most effective treatment: prospective, randomized, controlled trial. J Minim Invasive Gynecol. 2013;20(4):473.

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DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.