

## Gonadotropin-Releasing Hormone Agonists

### Goals:

- Restrict use of gonadotropin-releasing hormone (GnRH) agonists to medically appropriate conditions funded under the Oregon Health Plan.
- Promote use that is consistent with medical evidence and product labeling.

### Length of Authorization:

- Up to 6 months

### Requires PA:

- All GnRH agonists

### Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at [www.orpdl.org](http://www.orpdl.org)
- Searchable site for Oregon FFS Drug Class listed at [www.orpdl.org/drugs/](http://www.orpdl.org/drugs/)

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the diagnosis funded by OHP?	<b>Yes:</b> Go to #5	<b>No: For current age ≥ 21 years:</b> Pass to RPh. Deny; not funded by the OHP  <b>For current age &lt; 21 years:</b> Go to #3.
3. Will the prescriber consider switching to a preferred product, if appropriate? Message: <ul style="list-style-type: none"> <li>• Preferred products do not require a PA.</li> <li>• Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Oregon Pharmacy &amp; Therapeutics Committee.</li> </ul>	<b>Yes:</b> Inform prescriber of covered alternatives in class.	<b>No:</b> Go to #4
4. Is there documentation that the condition is of sufficient severity that it impacts the patient's health (e.g., quality of life, function, growth, development, ability to participate in school, perform activities of daily living, etc)?	<b>Yes:</b> Go to #5	<b>No:</b> Pass to RPh. Deny; medical necessity.
5. Is the diagnosis central precocious puberty or other endocrine disorder?	<b>Yes:</b> Go to #6	<b>No:</b> Go to #7

Approval Criteria		
6. Is the prescriber a pediatric endocrinologist?	<b>Yes:</b> Approve for up to 6 months.	<b>No:</b> Pass to RPh; deny for medical appropriateness.
7. Is the diagnosis gender dysphoria?	<b>Yes:</b> Approve for 1 year	<b>No:</b> Go to #8
8. Is the patient of childbearing potential and pregnant or actively trying to conceive?	<b>Yes:</b> Pass to RPh. Deny; medical appropriateness	<b>No:</b> Go to #9
9. Is there documentation that the provider and patient have discussed the teratogenic risks of the drug if the patient were to become pregnant?	<b>Yes:</b> Go to # 10	<b>No:</b> Pass to RPh. Deny; medical appropriateness.
10. Is this request for treatment of breast cancer or prostate cancer?	<b>Yes:</b> Approve up to 1 year	<b>No:</b> Go to #11
11. Is this request for leuprolide for the management of preoperative anemia due to uterine fibroids (leiomyoma)?	<b>Yes:</b> Approve for up to 3 months	<b>No:</b> Go to #12
12. Is this request for management of moderate to severe pain associated with endometriosis in a woman $\geq 18$ years of age?	<b>Yes:</b> Go to #13	<b>No:</b> Pass to RPh. Deny; medical appropriateness
13. Has the patient tried and failed an adequate trial of at least 1 of the preferred first line endometriosis therapy options for at least 3 months including administration of combined hormonal contraceptives or progestins (oral, depot injection, or intrauterine) alone? OR Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity the first-line therapy options?	<b>Yes:</b> Approve for 6 to 12 months, depending on selected medication.  *Note maximum recommended duration of therapy for nafarelin and goserelin is 6 months. Leuprolide therapy should not exceed 12 months. If requesting continuation of therapy beyond FDA-approved duration, pass to RPh. Deny; medical appropriateness.	<b>No:</b> Go to #14  *First-line therapy options such as hormonal contraceptives or progestins do not require PA
14. RPh only: All other indications need to be evaluated as to whether it is funded under the OHP. Refer unique situations to Medical Director of DMAP.		