BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

ORGOVYX™ (relugolix)
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Medical Necessity Requirements for ORGOVYX (relugolix)

Criteria for Initial Therapy:

Prescriber Qualifications
- Prescribed by or in consultation with an Oncologist or Urologist

Indication
- Advanced prostate cancer
- Other oncologic direct treatment use listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A

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Age Requirement
- 18 years or older

Baseline Clinical Evaluation
- At least 1 year of continuous androgen deprivation therapy for the management of androgen-sensitive advanced prostate cancer with ONE of the following:
  - Evidence of biochemical (PSA) or clinical relapse following local primary intervention with curative intent, such as surgery, radiation therapy, cryotherapy, or high-frequency ultrasound and not a candidate for salvage treatment by surgery
  - Newly diagnosed androgen-sensitive metastatic disease
  - Advanced localized disease unlikely to be cured by local primary intervention with either surgery or radiation with curative intent
- Baseline serum testosterone of greater than or equal to 150 ng/dL
- Baseline serum prostate-specific antigen (PSA) concentration:
  - Greater than 2.0 ng/mL
  - Post radical prostatectomy: greater than 0.2 ng/mL
  - Post radiotherapy, cryotherapy, or high-frequency ultrasound: greater than 2.0 ng/mL above post-interventional nadir
- Eastern Cooperative Oncology Group performance status of 0 or 1

Alternative Therapies
- Failure, contraindication per FDA label, intolerance to leuprolide acetate depot

Brand Specific Criteria
- Have failure, contraindication, or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the FDA (see Definitions section)

Documentation Requirements
- A completed request form must be submitted, including:
  - Chart notes
  - Lab results (testosterone, PSA, ECOG status)
  - Supporting clinical documentation

Initial Therapy Criteria Approval Duration
- 6 months OR end of plan year

Criteria for Continuation of Therapy (renewal therapy)
Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy

ORIGINAL EFFECTIVE DATE: 05/20/2021 | ARCHIVE DATE: | LAST REVIEW DATE: 05/15/2025 | LAST CRITERIA REVISION DATE: 05/16/2024

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Prescriber Qualifications
- Continues to be seen by or is in consultation with an Oncologist or Urologist

Clinical Response
- Achieved and maintained serum testosterone suppression to medical castration levels (less than 50 ng/dL)
- No disease progression

Adherence
- Adherence to the prescribed therapy regimen has been documented

Brand Specific Criteria
- Have failure, contraindication, or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the FDA (see Definitions section)

Safety
- No significant adverse drug effects such as:
  - QT/QTc interval prolongation
  - Severe hypersensitivity reaction (e.g., pharyngeal edema or angioedema)

Documentation Requirements
- Chart notes
- Supporting clinical documentation with evidence of improvement in given indication
- Lab values confirming safe use (testosterone, PSA)

Continuation Therapy Criteria Approval Duration
- 12 months OR end of plan year

Criteria for Off-Label Use Requests:

Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. Off-Label Use of Non-Cancer Medications

2. Off-Label Use of Cancer Medications

Description:

Orgovyx (relugolix) is a gonadotropin-releasing hormone (GnRH) receptor antagonist indicated for the treatment of adult patients with advanced prostate cancer. GnRH receptor antagonists competitively bind to pituitary GnRH

receptors, in so doing, reduce the release of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), and consequently testosterone.

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Gonadotropin-releasing hormone (GnRH) analogs or agonists: (Also referred to as luteinizing hormone releasing hormone (LHRH) agonists or analogs)

Zoladex (goserelin acetate) subcutaneous implant
Vantas (histrelin acetate) subcutaneous implant
Eligard (leuprolide acetate) subcutaneous injection
Lupron Depot (leuprolide acetate) intramuscular injection
Trelstar (triptorelin pamoate) intramuscular injection

Gonadotropin-releasing hormone antagonist:

Firmagon (dagarelix) subcutaneous injection
Orgovyx (relugolix)

Antiandrogens, oral: to maintain castrate serum levels of testosterone (< 50 ng/dL)

Zytiga (abiraterone acetate)
Erleada (apalutamide)
Casodex (bicalutamide)
Nubequa (darolutamide)
Xtandi (enzalutamide)
Flutamide
Nilandron (nilutamide)

ECOG Performance status:

Eastern Co-operative Oncology Group (ECOG) Performance Status	
Grade	ECOG description
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982

NCCN recommendation definitions:

Category 1:
Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A:
Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B:
Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3:
Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

Resources:

Orgovyx (relugolix) product information, revised by Sumitomo Pharma America, Inc. 10-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 21, 2025.

Dawson NA. Overview of the systemic treatment for recurrent or metastatic castration-sensitive prostate cancer In: UpToDate, Lee WR, Richie JR, Yushak M (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through March 2025. Topic last updated January 10, 2024. Accessed April 18, 2025.

Lee RJ, Smith MR. Initial systemic therapy for advanced, recurrent, and metastatic noncastrate (castration-sensitive) prostate cancer. In: UpToDate, Lee WR, Richie JR, Yushak M (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through March 2025. Topic last updated November 16, 2023. Accessed April 18, 2025.

Dawson NA, Leger P. Overview of the treatment of castration-resistant prostate cancer (CRPC). In: UpToDate, Lee WR, Richie JR, Sartor AO, Yushak M (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through March 2025. Topic last updated October 01, 2024. Accessed April 18, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Prostate Cancer Version 1.2025 – Updated December 04, 2024. Available at https://www.nccn.org. Accessed April 01, 2025.

Shore ND, Saad F, Cookson MS, et al: Oral Relugolix for Androgen-Depravation Therapy in Advanced Prostate Cancer. NEJM 2020; 382 Jun 4:2187-2196. Accessed March 03, 2021. Re-evaluated April 18, 2025.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.