

degarelix (Firmagon)

Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: [Blue Shield Oncology-Related Medication Policies](#).

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's [CarePro Provider Portal](#) to submit your request.

Place of Service

Office Administration

Outpatient Facility Infusion Administration

Infusion Center Administration

Drug Details

USP Category: HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)

Mechanism of Action: a gonadotropin-releasing hormone (GnRH), also known as a luteinizing hormone-releasing hormone (LHRH), antagonist

HCPCS:

J9155:Injection, degarelix, 1 mg

How Supplied:

80 mg single-dose vial (lyophilized powder in vial for reconstitution with prefilled syringe)

120 mg single-dose vial (lyophilized powder in vial for reconstitution with prefilled syringe)

Condition(s) listed in policy *(see coverage criteria for details)*

- Gender Dysphoria in Adolescents

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

The following condition(s) DO NOT require Prior Authorization/Preservice if ALL its parameters are met, otherwise Prior Authorization/Preservice is required.

Gender Dysphoria in Adolescents

Covered Doses:

Not to exceed 240 mg for the first dose, followed by 80 mg given subcutaneously no sooner than every 23 days

ICD-10:

F64.0, F64.1, F64.2, F64.9

References

1. AHFS. Available by subscription at <http://www.lexi.com>
2. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health (2022); 23(S1). S1-S260.
3. DrugDex. Available by subscription at <http://www.micromedexsolutions.com>
4. National Comprehensive Cancer Network. Prostate Cancer (Version 1.2025). Available at <http://www.nccn.org>.
5. Firmagon (degarelix) Prescribing Information. Ferring Pharmaceuticals Inc.: Parsippany, NJ: 2/2020.
6. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017;102(11): 3869-3903.

Review History

Date of Last Annual Review: 2Q2026

Changes from previous policy version:

- Effective 4/1/2026, medical necessity determinations will be made by Evolent for oncology-related indications

*Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee*