blue california
Promise Health Plan

degarelix (Firmagon)

Medical Benefit Drug Policy

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 No PSR on Comm
- Prostate Cancer-Advanced or Metastatic

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 California Code of Regulations (CCR), Title 22, Section 51303 and 51313 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.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Gender Dysphoria in Adolescents No PSR on Comm
Meets medical necessity if all the following are met:

Covered Doses:

Initial: 240 mg subcutaneously x1
Maintenance: Up to 80 mg subcutaneously monthly

Coverage Period:
indefinite

ICD-10:
F64.0, F64.1, F64.2, F64.9

Prostate Cancer-Advanced or Metastatic
Meets medical necessity if all the following are met:

Covered Doses:
Initial: 240 mg subcutaneously x1
Maintenance: Up to 80 mg subcutaneously monthly

Coverage Period:
indefinite

ICD-10:
C61, Z85.46

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 [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: 2Q2025
Changes from previous policy version:

- No clinical change following annual review.

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