I. Medication Description

Enlargement of the prostate, also known as benign prostatic hyperplasia (BPH), usually affects men over the age of 45. BPH is characterized by the presence of excess prostate tissue around the urethra. The urethra carries urine away from the bladder and thus an enlarged prostate can cause difficulty in urinating. This often leads to increased urinary frequency, incontinence, and the sensation of a distended bladder.

Finasteride (Proscar) is an oral synthetic steroid designed to inhibit the production of dihydrotestosterone (DHT) hormone by inhibiting type II 5α-reductase, an enzyme involved in the production of DHT. High levels of DHT are associated with prostate enlargement. Avodart, a type I and II 5α-reductase inhibitor, has similar inhibitory effects on DHT production and prostate gland enlargement as that of finasteride. Both Finasteride and dutasteride are indicated for the treatment of symptomatic BPH in men with an enlarged prostate gland to improve symptoms, moderate urine retention and reduce the need for surgery and prostatectomy.

II. Position Statement

Coverage is provided immediately for males greater than 45 years of age and for members who have a diagnosis of BPH (N40.0, N40.1) in their medical history.

Coverage is determined through a prior authorization process with supporting clinical documentation for all other requests.

III. Policy

Formulary 1: See Section A
Formulary 2: See Section A
Formulary 3/Exclusive: See Sections A and B
Formulary 4/AON: See Section A

A. Coverage is provided for the treatment of benign prostatic hyperplasia (BPH). Coverage is not provided for the treatment of alopecia or for the prevention of prostate cancer.

B. Coverage for Avodart or brand Proscar is provided after a trial with generic finasteride has first been documented.

IV. Quantity Limitations

- Proscar (finasteride): 30 tablets per each 30 days
- Avodart (dutasteride): 30 capsules per each 30 days
V. **Coverage Duration**

Coverage will be granted indefinitely through the life of this policy once the initial coverage criteria are met.

VI. **Coverage Renewal Criteria**

n/a

VII. **Billing/Coding Information**

- Proscar/finasteride – available as 5mg tablets
- Avodart/dutasteride— available as 0.5mg capsules

VIII. **Summary of Policy Changes**

- 12/15/12: no changes
- 12/15/13: policy updated to reflect coverage not provided for alopecia or for prevention of prostate cancer (alopecia section moved from exclusion section [now removed] to policy section)
- 1/1/15: no policy changes
- 7/1/15: formulary distinctions made
- 3/15/16: no policy changes

IX. **References**


*The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.*

*Drug therapy initiated with samples will not be considered as meeting medical necessity for coverage for non-preferred or prior authorized medications.*

*The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary agent will be considered.*

*The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.*