Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy.

## Prostate Treatment

### Covered Service:
Yes, as shown below.

### Prior Authorization Required:
Yes as shown below

### Additional Information:
None

### Prevea360 Health Plan Medical Policy:

1.0 The following interventions do not require prior authorization and are considered medically necessary for the treatment of benign prostate hypertrophy (BPH) for members as an alternative to transurethral resection of the prostate:

1.1 Medical management

1.2 Ultrasonic aspiration

1.3 Transurethral Microwave Thermotherapy (TUMT)

   1.3.1 TUMT does not require prior authorization and is considered medically necessary for the treatment of symptomatic BPH.

   1.3.2 TUMT is not considered medically necessary and therefore not covered for members with:

   1.3.2.1 History of a previous TUMT; OR

   1.3.2.2 Medication, neurological disorder, or renal or urinary tract disease which influences urinary tract function; OR

   1.3.2.3 Microwave-sensitive implants; prostate or bladder cancer; isolated and asymptomatic enlargement of the median lobe of the prostate; hip or femoral bone dysfunction; previous surgery or radiation of the prostate, rectum, urethra, or bladder neck.

1.4 Transurethral needle ablation (TUNA) also known as radiofrequency needle ablation (RFNA).

1.5 Transurethral electrovaporization of the prostate (TUVP)

1.6 Laser prostectomy

1.7 Cystoscopic procedure using small implants to separate encroaching prostatic lobes. Prostatic Urethral Lift (Urolift).

2.0 Endourethral prosthesis or urtheral stent, (eg. UroLume Urethral Stent) does not require a prior authorization and is considered medically necessary to relieve prostatic obstruction secondary to BPH in men at least 60 years of age, or men...
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under 60 who are poor surgical candidates, and whose prostates are at least 2.5 cm in length.

2.1 The endourethral prosthesis is also considered medically necessary for the treatment of recurrent bulbar urethral stenosis/stricture when previous therapeutic approaches such as dilation, urethrotomy, or urethroplasty have failed.

2.2 The endourethral prosthesis is considered experimental and investigational for other indications.

3.0 Prevea360 Health Plan considers the following approaches for the treatment of BPH to be experimental and investigational and therefore not covered for:

3.1 Endoscopic balloon dilation of the prostate

3.2 Transrectal thermal therapy (including transrectal microwave hyperthermia, transrectal radiofrequency hyperthermia, transrectal electrothermal hyperthermia and transrectal high-intensity focused ultrasound).

3.3 Cryosurgical ablation

3.4 Interstitial laser coagulation

3.5 Water induced thermotherapy (also known as hot-water thermoablation and theromourethral hot-water therapy)

3.6 Plasma kinetic vaporization

3.7 Temporary prostatic urethral stent

3.8 Absolute ethanol injection (transurethral)

3.9 Botulinum toxin

4.0 Prevea360 Health Plan considers the following medically necessary for the treatment of prostate cancer:

4.1 Prostate Brachytherapy, Seed Implantation (Transperineal Implantation of Radioisotopes) does not require prior authorization and is considered medical necessary therapy for patients with prostate cancer

4.2 Cryosurgery as salvage therapy for local recurrence after primary treatment for prostate cancer requires prior authorization and may be considered medically necessary for members who have undergone a radical prostatectomy or radiation therapy during treatment.

4.3 Cryoablation of the prostate as a primary treatment for prostate cancer requires prior authorization and may be considered medically necessary for members with clinically localized prostate cancer stages:

4.3.1 T1-clinically unapparent tumors and neither palpable nor visible by imaging; OR

4.3.2 T2-are palpable and appear confined with the prostate; OR
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4.3.3 T-3 tumors extend through the prostatic capsule or into the seminal vesicles; **AND**

4.3.4 Who are not suitable candidates for primary therapy with standard treatment or surgery.

4.4 Intensity-Modulated Radiotherapy (IMRT) **requires** prior authorization. Please refer to [MP9426](#) for criteria.

4.5 Stereotactic Radiosurgery for treatment of prostate cancer **requires** prior authorization. Please refer to [MP9459](#) for criteria.

5.0 The prostate cancer vaccine sipuleucel-T (PROVENGE) **requires** prior authorization and is considered medically necessary for the treatment of adults with metastatic castrate-resistant prostate cancer who:

5.1 Are asymptomatic or minimally symptomatic with Eastern Cooperative Oncology Group (ECOG) performance status 0-1; **AND**

5.2 Have no visceral metastases; **AND**

5.3 Have testosterone levels < 50 ng/dL or below lowest level of normal; **AND**

5.4 Have a life expectancy of greater than six months.

5.5 The prostate cancer vaccine is considered experimental and investigational for all other indications (e.g. prevention of prostate cancer and treatment of localized prostate cancer) and is therefore not covered.
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<thead>
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