

Clinical Policy: Enzalutamide (Xtandi)

Reference Number: CP.PHAR.106

Effective Date: 10.12

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Enzalutamide (Xtandi®) is an androgen receptor inhibitor.

FDA Approved Indication(s)

Xtandi is indicated for the treatment of patients with:

- Castration-resistant prostate cancer (CRPC)
- Metastatic castration-sensitive prostate cancer (CSPC)
- Non-metastatic castration-sensitive prostate cancer (nmCSPC) with biochemical recurrence at high risk for metastasis

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Xtandi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Prostate Cancer** (must meet all):

1. Diagnosis of one of the following (a, b, or c):
 - a. CRPC, as evidenced by disease progression despite bilateral orchiectomy or other androgen deprivation therapy (ADT) (*see Appendix D*);
 - b. Metastatic CSPC;
 - c. nmCSPC;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age \geq 18 years;
4. For Xtandi requests, member must use generic enzalutamide, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for CRPC or metastatic CSPC, prescribed concurrently with a gonadotropin-releasing hormone (GnRH) analog or member has had a bilateral orchiectomy;
6. If prescribed concurrently with Talzena®*, request is for metastatic CRPC;
* Prior authorization may be required for Talzena
7. For non-metastatic CRPC, request is for secondary hormone therapy with PSA doubling time \leq 10 months (off-label);
8. If request is for nmCSPC, member has biochemical recurrence at high risk for metastasis as evidenced by both of the following (a and b):

- a. Prostate-specific antigen (PSA) doubling time ≤ 9 months;
- b. One of the following (i or ii):
 - i. PSA values ≥ 1 ng/mL if member had prior radical prostatectomy (with or without radiotherapy) as the primary treatment for prostate cancer;
 - ii. PSA values ≥ 2 ng/mL above the nadir (lowest point) if member had prior radiotherapy only;
9. Request does not exceed health plan-approved quantity limit, if applicable;
10. Request meets one of the following (a, b, c, or d):*
 - a. If prescribed concomitantly with a strong CYP2C8 inhibitor (e.g., gemfibrozil): Dose does not exceed both of the following (i and ii):
 - i. 80 mg per day;
 - ii. 2 capsules or 1 tablet per day;
 - b. Dose does not exceed both of the following (i and ii):
 - i. 160 mg per day;
 - ii. 4 capsules or 2 tablets per day;
 - c. If prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital): Dose does not exceed both of the following (i and ii):
 - i. 240 mg per day;
 - ii. 6 capsules or 3 tablets per day;
 - d. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prostate Cancer (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Xtandi for prostate cancer and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Xtandi requests, member must use generic enzalutamide, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, c, or d):*
 - a. If prescribed concomitantly with a strong CYP2C8 inhibitor (e.g., gemfibrozil): New dose does not exceed both of the following (i and ii):
 - i. 80 mg per day;
 - ii. 2 capsules or 1 tablet per day;
 - b. New dose does not exceed both of the following (i and ii):
 - i. 160 mg per day;
 - ii. 4 capsules or 2 tablets per day;
 - c. If prescribed concomitantly with a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, and phenobarbital): New dose does not exceed both of the following (i and ii):
 - i. 240 mg per day;
 - ii. 6 capsules or 3 tablets per day;
 - d. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies –

CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADT: androgen deprivation therapy
CRPC: castration-resistant prostate cancer
CSPC: castration-sensitive prostate cancer
FDA: Food and Drug Administration
GnRH: gonadotropin-releasing hormone
LHRH: luteinizing hormone-releasing hormone

NCCN: National Comprehensive Cancer Network
nmCSPC: non-metastatic castration-sensitive prostate cancer
PSA: prostate-specific antigen

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- CRPC is prostate cancer that progresses clinically, radiographically, or biochemically despite castrate levels of serum testosterone (< 50 ng/dL). Per the NCCN, ADT should be continued in the setting of CRPC while additional therapies are applied.
 - Examples of ADT include:
 - Bilateral orchiectomy (surgical castration)
 - Luteinizing hormone-releasing hormone (LHRH) agonist given with or without an anti-androgen:
 - LHRH agonists: Zoladex[®] (goserelin), Vantas[®] (histrelin), leuprolide (Lupron Depot[®], Eligard[®]), and Trelstar[®] (triptorelin)
 - Anti-androgens: bicalutamide (Casodex[®]), flutamide (Eulexin[®]), nilutamide (Nilandron[®]), Xtandi[®] (enzalutamide), Erleada[®] (apalutamide)
 - LHRH antagonist: Firmagon[®] (degarelix), Orgovyx[®] (relugolix)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRPC, metastatic CSPC, nmCSPC	<p>160 mg (two 80 mg tablets) PO QD.</p> <p>Patients with CRPC or metastatic CSPC receiving Xtandi should also receive a GnRH analog concurrently or should have had bilateral orchiectomy.</p> <p>Patients with nmCSPC with high-risk biochemical recurrence may be treated with Xtandi with or without a GnRH analog. For patients who receive Xtandi with or without a GnRH analog, treatment can be suspended if PSA is undetectable (< 0.2 ng/mL) after</p>	160 mg/day; 240 mg/day if taking a strong CYP3A4 inducer

Indication	Dosing Regimen	Maximum Dose
	36 weeks of therapy. Reinitiate treatment when PSA has increased to ≥ 2.0 ng/mL for patients who had prior radical prostatectomy or ≥ 5.0 ng/mL for patients who had prior primary radiation therapy.	

VI. Product Availability

- Capsule: 40 mg
- Tablets: 40 mg, 80 mg

VII. References

1. Xtandi Prescribing Information. Northbrook, IL: Astellas Pharma US.; March 2025. Available at: <https://www.xtandi.com/>. Accessed October 13, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at https://www.nccn.org/professionals/drug_compendium/content/. Accessed November 5, 2025.
3. National Comprehensive Cancer Network. Prostate Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed November 5, 2025.
4. Virgo KS, Basch E, Loblaw DA, et al. Second-Line Hormonal Therapy for Men with Chemotherapy-Naïve Castration-Resistant Prostate Cancer. American Society of Clinical Oncology (ASCO). Published online April 25, 2017, DOI: 10.1200/JCO.2017.72.8030. Available at: <https://www.asco.org/practice-patients/guidelines/genitourinary-cancer#/25251>. Accessed November 5, 2025.
5. Virgo KS, Rumble RB, Talcott J. Initial Management of Noncastrate Advanced, Recurrent, or Metastatic Prostate Cancer: ASCO Guideline Update Journal of Clinical Oncology 2023 41:20, 3652-3656. Available at: <https://ascopubs.org/doi/full/10.1200/JCO.23.00155>. Accessed November 5, 2025.
6. Basch E, Loblaw DA, Oliver TK, et al. Systemic Therapy in Men with Metastatic Castration-Resistant Prostate Cancer (CRPC). American Society of Clinical Oncology (ASCO). Published online before print September 8, 2014. Available at: <https://www.asco.org/practice-patients/guidelines/genitourinary-cancer#/9496>. Accessed November 5, 2025.
7. Freedland SJ, de Almeida Luz M, De Giorgi U, et al. Improved Outcomes with Enzalutamide in Biochemically Recurrent Prostate Cancer. N Engl J Med. 2023 Oct 19;389(16): 1453-1465.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: per November SDC and prior clinical guidance, removed HIM line of business (separated to new policy HIM.PA.164); added redirection to generic abiraterone for members with metastatic disease; references reviewed and updated.	11.30.21	02.22
Template changes applied to other diagnoses/indications.	09.30.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2023 annual review: added Commercial and HIM lines of business (CP.CPA.203 and HIM.PA.164 retired); removed redirection to abiraterone; references reviewed and updated.	11.03.22	02.23
1Q 2024 annual review: added requirement per NCCN if prescribed concurrently with Talzenna, request is for metastatic CRPC; removed abiraterone from Appendix B as redirection is not required; references reviewed and updated. RT4: added new indication for nmCSPC.	10.04.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	10.17.24	02.25
1Q 2026 annual review: per NCCN Compendium added off-label use in non-metastatic CRPC as secondary hormone therapy with PSA doubling time ≤ 10 months; added template language “Request does not exceed health plan-approved quantity limit; revised initial approval duration from 6 to 12 months; if applicable”; references reviewed and updated.	10.13.25	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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