



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Triptodur

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Effective Date: 7/15/2024

Last Review Date: 5/2024

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input checked="" type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Triptodur under the patient's prescription drug benefit.

### Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

#### A. FDA-Approved Indication

Triptodur is indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty (CPP).

#### B. Compendial Uses

1. Preservation of ovarian function
2. Prevention of recurrent menstrual related attacks in acute porphyria

All other indications are considered experimental/investigational and not medically necessary.

### Applicable Drug List:

Triptodur

### Policy/Guideline:

#### Documentation:

Submission of the following information is necessary to initiate the prior authorization review: For central precocious puberty, laboratory report or medical record of a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.

#### Criteria for Initial Approval:

##### A. **Central precocious puberty (CPP)**

Note: Requests for Triptodur for CPP require that the patient is unable to take leuprolide acetate injection kit 1mg/0.2mL for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.



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1. Authorization of 12 months may be granted for treatment of CPP in a female member when all of the following criteria are met:
  - i. Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging (e.g., computed tomography [CT] scan, magnetic resonance imaging [MRI]).
  - ii. The diagnosis of CPP has been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay.
  - iii. The assessment of bone age versus chronological age supports the diagnosis of CPP.
  - iv. The member was less than 8 years of age at the onset of secondary sexual characteristics.
2. Authorization of 12 months may be granted for treatment of CPP in a male member when all of the following criteria are met:
  - i. Intracranial tumor has been evaluated by appropriate lab tests and diagnostic imaging (e.g., CT scan, MRI).
  - ii. The diagnosis of CPP has been confirmed by a pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay.
  - iii. The assessment of bone age versus chronological age supports the diagnosis of CPP.
  - iv. The member was less than 9 years of age at the onset of secondary sexual characteristics.

#### **B. Preservation of ovarian function**

Authorization of 3 months may be granted for preservation of ovarian function when the member is premenopausal and undergoing chemotherapy.

#### **C. Prevention of recurrent menstrual related attacks in acute porphyria**

Authorization of 12 months may be granted for prevention of recurrent menstrual related attacks in members with acute porphyria when the requested medication is prescribed by or in consultation with a physician experienced in the management of porphyrias.

#### **Continuation of Therapy:**

##### **A. Central precocious puberty (CPP)**

1. Authorization of up to 12 months may be granted for continuation of therapy for CPP in a female member if the member is currently less than 12 years of age and the member meets both of the following:
  - i. The member is currently receiving the requested medication through a paid pharmacy or medical benefit.



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- ii. The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement).
2. Authorization of up to 12 months may be granted for continuation of therapy for CPP in a male member if the member is currently less than 13 years of age and the member meets both of the following:
  - i. The member is currently receiving the requested medication through a paid pharmacy or medical benefit.
  - ii. The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement).

#### B. All other indications

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

#### Approval Duration and Quantity Restrictions:

**Approval:** Preservation of ovarian function – 3 months; all others – 12 months

#### References:

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5. Houk CP, Kunselman AR, Lee PA. Adequacy of a single unstimulated luteinizing hormone level to diagnose central precocious puberty in girls. *Pediatrics*. 2009;123:e1059-e1063.
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11. Cheuiche AV, da Silveira LG, de Paula LCP, et al. Diagnosis and management of precocious sexual maturation: an updated review. *Eur J Pediatr.* 2021;180(10):3073-3087.