SmartHealth Ascension

Triptorelin Pamoate

(Triptodur®) J3316 (3.75mg)

Covered with prior authorization

Triptodur® (triptorelin pamoate) may be authorized when the following criteria are met:

Central Precocious Puberty (CPP)

Individual meets ALL of the following criteria:

- Onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; **AND**
- Confirmation of diagnosis as defined by **ONE** of the following:
  - Pubertal basal level of luteinizing hormone (LH) greater than or equal to 0.3 mIU/mlD.
  - Pubertal luteinizing hormone (LH) response to a GnRH stimulation test.

Exclusion criteria:

- Peripheral Precocious Puberty (Also known as Gonadotropin-Releasing Hormone-Independent Precocious Puberty).
- Product use for non-FDA approved indications or indications not supported by industry-accepted guidelines.
- Doses, durations, or dosing intervals that exceed FDA maximum limits for any FDA-approved indication or are not supported by industry-accepted practice guidelines or peer-reviewed literature for the relevant off-label use.

Initial approval duration:

- Initial approval duration is up to 12 months.

Reauthorization approval duration:

- Reauthorization approval duration is up to 12 months.

Reauthorization Criteria:

Triptodur® (triptorelin pamoate) is considered medically necessary for continued use when initial criteria are met **AND** there is documentation of beneficial response.

Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

U.S. Food and Drug Administration:

This section is to be used for informational purposes. FDA approval alone is not a basis for coverage.

Triptodur® (triptorelin pamoate) is a gonadotropin-releasing hormone (GnRH) agonist indicated for the treatment of pediatric patients with central precocious puberty.

References:

1. Triptodur® [prescribing information]. Atlanta, GA: Arbor Pharmaceuticals; October 2018.
2. Eugster EA. Treatment of central precocious puberty. J Endo Soc. 2019;3:965-972.

Date	Summary of Changes
August 2022	Criteria for use summary developed by the Ascension Medical Specialty Prior Authorization Team.
September 2022	Criteria for use summary approved by the Ascension Ambulatory Care Expert Review Panel.
October 2022	Criteria for use summary approved by the Ascension Therapeutic Affinity Group.

If you have questions, call 833-980-2352 to speak to a member of the Ascension Rx prior authorization team, or email your questions to smarthealthspecialty@ascension.org.