



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Triptodur

Page: 1 of 3

Effective Date: 10/15/2025

Last Review Date: 9/2025

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.

FDA-Approved Indications¹

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

Compendial Uses

- Preservation of ovarian function^{7,8}
- Prevention of recurrent menstrual related attacks in acute porphyria^{9,10}

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.

Prescriber Specialties^{9,10}

For prevention of recurrent menstrual related attacks in acute porphyria, this medication must be prescribed by or in consultation with a provider experienced in the management of porphyrias.

Coverage Criteria

Central Precocious Puberty (CPP)^{1-6,11}

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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Authorization of 12 months may be granted for treatment of CPP when all of the following criteria are met:

- 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.
- The assessment of bone age versus chronological age supports the diagnosis of CPP.
- The member meets either of the following criteria:
 - The member is a female and was less than 8 years of age at the onset of secondary sexual characteristics.
 - The member is a male and was less than 9 years of age at the onset of secondary sexual characteristics.
- The pathologic cause of CPP has been assessed (e.g., imaging screening for intracranial tumors, genetic testing for familial CPP [e.g., MKRN3 or DLK1 mutations]).

Preservation of Ovarian Function^{7,8}

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

Prevention of Recurrent Menstrual-Related Attacks in Acute Porphyria^{9,10}

Authorization of 12 months may be granted for prevention of recurrent menstrual-related attacks in members with acute porphyria.

Continuation of Therapy

Central Precocious Puberty (CPP)^{2,4,11}

Authorization of up to 12 months may be granted for continued treatment for CPP when the member meets all of the following criteria:

- The member is currently receiving the requested medication through a paid pharmacy or medical benefit.
- The member is either a female less than 12 years of age or a male less than 13 years of age.
- The member is not experiencing treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement).



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All Other Indications

All members (including new members) requesting authorization for continuation of therapy must meet all all requirements in the coverage criteria section.

Approval Duration and Quantity Restrictions:

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

References:

1. Kletter GB, Klein KO, Wong YY. A pediatrician's guide to central precocious puberty. *Clin Pediatr.* 2015;54:414-424.
2. Carel J, Eugster EA, Rogol A, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics.* 2009;123:e752-e762.
3. Bangalore Krishna K, Fuqua JS, Rogol AD, et al. Use of gonadotropin-releasing hormone analogs in children: Update by an international consortium. *Horm Res Paediatr.* 2019;91(6):357-372.
4. Bangalore Krishna K, Silverman LA. Diagnosis of central precocious puberty. *Endocrinol Metab Clin North Am.* 2024;53(2):217-227.
5. Kaplowitz P, Bloch C, the Section on Endocrinology. Evaluation and referral of children with signs of early puberty. *Pediatrics.* 2016;137:e20153732.
6. Moore HCF, Unger JM, Phillips K-A, et al. Goserelin for ovarian protection during breast-cancer adjuvant chemotherapy. *N Engl J Med.* 2015;372:923-32.
7. Clowse MEB, Behera MA, Anders CK, et al. Ovarian preservation by GnRH agonists during chemotherapy: a meta-analysis. *J Womens Health (Larchmt).* 2009 Mar; 18(3): 311-319.
8. Stein P, Badminton M, Barth J, et al. British and Irish Porphyria Network. Best practice guidelines on clinical management of acute attacks of porphyria and their complications. *Ann Clin Biochem.* 2013 May;50(Pt 3):217-23.
9. Innala E, Bäckström T, Bixo M, et al. Evaluation of gonadotrophin-releasing hormone agonist treatment for prevention of menstrual-related attacks in acute porphyria. *Acta Obstet Gynecol* 2010;89:95-100.
10. 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.
11. Popovic J, Geffner ME, Rogol AD, et al. Gonadotropin-releasing hormone analog therapies for children with central precocious puberty in the United States. *Front Pediatr.* 2022;10:968485. doi:10.3389/fped.2022.968485