JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP028
		Effective Date	04/08/2011
		Review Date	10/21/2020
	Subject **Supprelin LA (histrelin acetate) and Triptodur (triptorelin)**	*Revision Date*	09/07/2023
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: supprelin LA, triptodur

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I. POLICY

A. Supprelin LA (histrelin acetate) and Triptodur (triptorelin) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. **Supprelin LA** may be approved for patients meeting the following:
   1. Central Precocious Puberty
      a. Documentation confirming diagnosis and both of the following:
         I. Patient is 2 years of age or older
         II. Documented inadequate response to, or intolerance with Lupron and Triptodur
   2. Hormone Suppression of Puberty
      a. Documentation confirming a diagnosis of gender dysphoria through medical evaluation by a health professional in accordance with TRICARE guidance, and other applicable JHHC policies AND
      b. Documentation of trans-identified patient with Tanner Stage 2 or above

B. **Triptodur** may be approved for patients meeting the following criteria:
   1. Central Precocious Puberty
      a. Documentation confirming diagnosis and both of the following:
         I. Patient is 2 years of age or older
         II. Documented inadequate response, intolerance, or contraindication to Lupron injections
   2. Hormone Suppression of Puberty
      a. Documentation confirming a diagnosis of gender dysphoria through medical evaluation by a health professional in accordance with TRICARE guidance, and other applicable JHHC policies AND
      b. Documentation of trans-identified patient with Tanner Stage 2 or above

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be restricted to 12 months of therapy.

B. Continuation of therapy may be approved in 12-month intervals with documentation showing continued benefit.

IV. EXCLUSIONS

A. Coverage will not be provided for:
   1. Children less than 2 years of age
   2. Any indication or usage that is not FDA-approved, or guideline-supported

B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. RECOMMENDED DOSAGE

All FDA approved dosage(s) and dosing interval(s) for the FDA approved indication(s).

VI. CODES

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Supprelin LA 50 MG KIT Histrelin implant	J9226
Triptodur 22.5 MG SRER Injection, triptorelin, extended-release, 3.75 mg	J3316

VII. REFERENCES

1. Carel JC, Leger J., Precocious Puberty. New England Journal of Medicine, 5/29/08, vol. 358:2366-2377, #22.
2. Blondell RC, Foster MB, Kamlesh, DC. Disorders of Puberty. American Family Physician, July 1999; 60:209-24
3. Supprelin LA (histrelin acetate) subcutaneous implant [package insert]. Chadds Ford, PA: Endo Pharmaceuticals Solutions Inc.; September 2010.
4. Triptodur ER (triptorelin) injectable suspension [package insert]. Atlanta, GA: Arbor Pharmaceuticals, LLC; June 2017
5. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017:102(11):3869–3903.
6. TRICARE Policy Manual 6010.60-M, April 1, 2015.Chapter 7 Section 1.3: Gender Dysphoria (GD) and Gender-Affirming Health Care For Dates of Service On or After July 1, 2022. Available at: https://manuals.health.mil/pages/DisplayManualHtmlFile/2023-09-06/AsOf/TP15/C7S1_3.html

VIII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE

03/30/2016	Clarified authorization duration, removed background information, modified layout
03/17/2017	Addition of criteria for hormone suppression therapy for patients diagnosed with gender dysphoria per DHMH guidance, and applicable JHHC policies
07/27/2017	Updated Exclusions section regarding physician samples
02/20/2018	Added clinical criteria for Triptodur
07/01/2018	Removed EHP Line of Business
06/05/2019	Converted from MEDS to MMDP policy
01/15/2020	No policy changes- presented policy for USFHP adoption effective 3/1/2020
10/08/2020	Clarified criteria for Supprelin LA, and added hormone suppression of puberty criteria for Triptodur
11/10/2021	Removed Priority Partners as an applicable LOB
09/07/2023	Clarified criteria wording, and added a reference to the TRICARE Guidance for Gender Dysphoria

Review Date: 04/08/2011, 01/01/2013, 04/19/2017, 4/18/2018, 07/17/2019, 01/15/2020, 10/21/2020

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