Clinical Policy: Triptorelin Pamoate (Trelstar, Triptodur)

Reference Number: ERX.SPA.45
Effective Date: 07.01.16
Last Review Date: 11.21
Line of Business: Commercial, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Triptorelin pamoate (Trelstar®, Triptodur®) is a gonadotropin-releasing hormone (GnRH) receptor agonist.

FDA Approved Indication(s)
Trelstar is indicated for the palliative treatment of advanced prostate cancer.

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

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Trelstar and Triptodur are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prostate Cancer (must meet all)**:**
1. Diagnosis of prostate cancer;
2. Request is for Trelstar;
3. Prescribed by or in consultation with an oncologist or urologist;
4. Age ≥ 18 years;
5. Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: leuprolide acetate injection (generic), Eligard, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg);
   **Prior authorization may be required*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.75 mg per 4 weeks, 11.25 mg per 12 weeks, or 22.5 mg per 24 weeks;
   b. 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. Central Precocious Puberty (must meet all)**:**
1. Diagnosis of CPP confirmed by all of the following (a, b, and c):
   a. Elevated basal luteinizing hormone (LH) level > 0.2 - 0.3 mIU/L (dependent on type of assay used) and/or elevated leuprolide-stimulated LH level > 3.3 - 5 IU/L (dependent on type of assay used);
   b. Difference between bone age and chronological age was > 1 year (bone age-chronological age);
   c. Age at onset of secondary sex characteristics is < 8 years if female, or < 9 years if male;
2. Request is for Triptodur;

3. Prescribed by or in consultation with a pediatric endocrinologist;
4. Member meets one of the following age requirements (a or b):
   a. Female: 2 - 11 years;
   b. Male: 2 - 12 years;
5. Failure of leuprolide acetate injection (generic), unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required*
6. Dose does not exceed 22.5 mg per 24 weeks.

Approval duration: 12 months

C. Gender Dysphoria, Gender Transition (off-label) (must meet all)**:**

1. Diagnosis of gender dysphoria or request is for gender transition;
2. Prescribed by or in consultation with an endocrinologist and an expert in gender dysphoria and transgender medicine (e.g., mental health professional such as psychologist, psychiatrist);
3. Age and pubertal development - meets (a or b):
   a. Member has reached or passed through Tanner Stage 2* and is < 18 years of age;

      **Age ranges approximating Tanner Stage 2 pubertal development extend from 8 to 13 years of age in girls and 9 to 14 years of age in boys.*
   b. Member is ≥ 18 years of age and has failed to achieve physiologic hormone levels with gender-affirming hormonal therapy (e.g., estrogen, testosterone) unless contraindicated or clinically significant adverse effects are experienced;
4. Member demonstrates understanding of expected GnRH analogue treatment outcomes and has given consent for such treatment;
5. If member has a psychiatric comorbidity, member is followed by mental health provider;
6. Psychosocial support will be provided during treatment;
7. Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: leuprolide acetate injection (generic), Eligard, Lupron Depot;
   **Prior authorization may be required*
8. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

D. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Prostate Cancer (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Trelstar for prostate cancer and has received this medication for at least 30 days;
2. Request is for Trelstar;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 3.75 mg per 4 weeks, 11.25 mg per 12 weeks, or 22.5 mg per 24 weeks;
   b. 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. Central Precocious Puberty (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met all initial approval criteria;
2. Request is for Triptodur;
3. Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: decreased growth velocity, cessation of menses, softening of breast tissue or testes, arrested pubertal progression;
4. Member meets one of the following age requirement (a or b):
   a. Female: ≤ 11 years;
   b. Male: ≤ 12 years.
5. If request is for a dose increase, new dose does not exceed 22.5 mg per 24 weeks.

Approval duration: 12 months

C. Gender Dysphoria, Gender Transition (off-label) (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

D. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CPP: central precocious puberty
FDA: Food and Drug Administration
GnRH: gonadotropin-releasing hormone
LH: luteinizing hormone
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Leuprolide acetate injection (generic)	Prostate Cancer - Palliative Therapy SC: 1 mg per day	1 mg per day
Lupron Depot® 7.5, 22.5, 30, 45 (leuprolide acetate)	Prostate Cancer - Palliative Therapy IM: 7.5 mg per 4 weeks, 22.5 mg per 12 weeks, 30 mg per 16 weeks, or 45 mg per 24 weeks	See regimen
Eligard® (leuprolide acetate)	Prostate Cancer - Palliative Therapy SC: 7.5 mg per month, 22.5 mg per 3 months, 30 mg per 4 months, or 45 mg per 6 months	See regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Leuprolide acetate injection (generic)	CPP: • Diagnostic: 20 mcg/kg SC or as needed; • Treatment: Initial: 50 mcg/kg/day SC; titrate dose upward by 10 mcg/kg/day if down-regulation is not achieved (higher mg/kg doses may be required in younger children).	See regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Hypersensitivity to triptorelin or any other component of the product, or other GnRH agonists or GnRH
  - Pregnancy (Triptodur)
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Triptorelin acetate (Trelstar)	Prostate cancer - palliative therapy	IM: 3.75 mg per 4 weeks, 11.25 mg per 12 weeks, 22.5 mg per 24 weeks	See regimen
Triptorelin acetate (Triptodur)	CPP	IM: 22.5 mg per 24 weeks	See regimen

VI. Product Availability

Drug Name	Availability
Triptorelin acetate (Trelstar)	Single-dose vial for reconstitution: 3.75 mg, 11.25 mg, 22.5 mg
Triptorelin acetate (Triptodur)	Single-dose vial for reconstitution: 22.5 mg

VII. References

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4. National Comprehensive Cancer Network. Prostate cancer (Version 2.2020). Available at https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed July 14, 2021.
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Gender Dysphoria

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14. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed July 14, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2018 annual review: no significant changes; for prostate cancer, summarized NCCN and FDA-approved uses for improved clarity (limited to diagnosis, added specialist involvement in care, and added continuation of care; references reviewed and updated.	08.07.18	11.18
Addition of gender dysphoria as off-label use.	07.16.19	08.19
4Q 2019 annual review: added redirection to formulary leuprolide products; for prostate cancer added option for urologist prescribing; references reviewed and updated.	08.01.19	11.19
4Q 2020 annual review: for gender dysphoria indication added redirection to one leuprolide product; references reviewed and updated.	07.15.20	11.20
4Q 2021 annual review: added gender transition to gender dysphoria criteria set; references reviewed and updated.	07.14.21	11.21

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.