Reference number(s)
4926-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☐
Standard Control – Choice (SCCF)	☐
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☐
Advanced Control Specialty – Choice (ACSCF)	☐
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☑
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Central Precocious Puberty

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with Marketplace (MF).

Plan Design Summary

This program applies to the central precocious puberty products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are initiating a new treatment regimen with the targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Central Precocious Puberty Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• Lupron Depot-PED (leuprolide acetate) • Supprelin LA (histrelin acetate) • Triptodur (triptorelin)
Target	• Fensolvi (leuprolide acetate)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred products.

Coverage for Fensolvi is provided when either of the following criteria is met:

- Member is currently receiving treatment with Fensolvi, excluding when Fensolvi is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with all of the preferred products (Lupron Depot-PED, Supprelin LA, and Triptodur).

References

1. Fensolvi [package insert]. Fort Collins, CO: Tolmar; April 2023.
2. Lupron Depot-PED [package insert]. North Chicago, IL: AbbVie Inc.; April 2023.
3. Supprelin LA [package insert]. Malvern, PA: Endo Pharmaceuticals Inc.; April 2022.
4. Triptodur [package insert]. Woburn, MA: Azurity Pharmaceuticals, Inc.; November 2023.