UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1221-10
Program	Prior Authorization/Notification
Medication	Xermelo® (telotristat ethyl)
P&T Approval Date	6/2017, 6/2018, 6/2019, 6/2020, 6/2021, 6/2022, 6/2023, 6/2024. 6/2025, 6/2026
Effective Date	9/1/2026

1. Background:

Xermelo (telotristat ethyl) is a tryptophan hydroxylase inhibitor indicated for the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy.

2. Coverage Criteria[a]:

A. Carcinoid Syndrome Diarrhea

1. **Initial Authorization**

a. **Xermelo** will be approved based on **all** of the following criteria:

(1) Diagnosis of carcinoid syndrome diarrhea

-AND-

(2) Diarrhea is inadequately controlled with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)

-AND-

(3) Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Xermelo** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Xermelo

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

© 2026 UnitedHealthcare Services, Inc.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Xermelo® [package insert]. Deerfield, IL: TerSera Therpeutics LLC; September 2022.

Program	Prior Authorization/Notification – Xermelo (telotristat)
Change Control	
6/2017	New program.
6/2018	Annual review with no change to criteria.
6/2019	Annual review with no changes to criteria.
6/2020	Annual review with no changes to criteria or reference.
6/2021	Annual review with no changes to criteria.
6/2022	Annual review with no changes to criteria. Updated references.
6/2023	Annual review. Added Lanreotide to SSA examples. Updated reference and added state mandate footnote.
6/2024	Annual review. Updated initial authorization duration to 12 months.
6/2025	Annual review with no changes to criteria.
6/2026	Annual review with no changes to criteria.

© 2026 UnitedHealthcare Services, Inc.