UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Copper Chelating Agents

Program	Prior Authorization- Copper chelating Agents
Medication	Copper Chelating Agents [Syprine (trientine), Cuprimine (penicillamine), Depen Titratable (penicillamine)]
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	9/2014
Pharmacy and Therapeutics Approval Date	6/2020
Effective Date	8/2020

1. Background:

Depen and Cuprimine are indicated in the treatment of Wilson's disease, cystinuria, and in patients with severe, active rheumatoid arthritis who have failed to respond to an adequate trial of conventional therapy.

Syprine is indicated in the treatment of patients with Wilson's disease who are intolerant of penicillamine.

2. Coverage Criteria:

A. Depen Titratable

1. Initial Authorization

a. **One** of the following diagnoses:

(1) Wilson's disease (i.e., hepatolenticular degeneration)
(2) Cystinuria
(3) Severe active rheumatoid arthritis

Authorization will be issued for 12 months.

2. Reauthorization

Note this section only applies for diagnosis of severe active rheumatoid arthritis only. For Wilson's disease and cystinuria, patient would continue to go through initial authorization for a diagnosis check only.

a. **Depen Titratable** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to Depen Titratable therapy

Authorization will be issued for 12 months.

B. Cuprimine

1. Initial Authorization

a. **One** of the following diagnoses:

(1) Wilson's disease (i.e., hepatolenticular degeneration)
(2) Cystinuria
(3) Severe active rheumatoid arthritis

-AND-

b. History of failure or intolerance to Depen (penicillamine)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Cuprimine** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to Cuprimine therapy

Authorization will be issued for 12 months.

C. Syprine

1. Initial Authorization

a. Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

-AND-

b. History of failure, contraindication, or intolerance to Depen (penicillamine) or Cuprimine (penicillamine)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Syprine** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to Syprine therapy

Authorization will be issued for 12 months.

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. Cuprimine Prescribing Information. Aton Pharma, Inc., November2019.
2. Syprine Prescribing Information. Aton Pharma, Inc., December 2016.
3. Depen Titratable Prescribing Information. Meda Pharmaceuticals. July 2018.

Program	Prior Authorization- Copper Chelating Agents
Change Control	
Date	Change
9/2014	New guideline.
12/2015	• Added Depen Titratable formulation to the policy due to addition to the Preferred Drug List. Prior authorization required. • Changed approval length to 1 year • Added Depen Titratable to list of references
6/2016	Updated policy template. Added reauthorization criteria.
6/2017	Annual review. Updated references.
9/2017	Added note under reauthorization criteria for Depen Titratable that criteria will only apply to diagnosis of severe active rheumatoid arthritis to allow for Dx to Rx implementation.
6/2018	Annual review. No changes to criteria.
6/2019	Annual review. Formatted background to align with other programs.
6/2020	Annual review. Updated references.