UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Nityr

Program	Prior Authorization
Medication	Nityr (nitisinone) tablets
Markets in Scope	California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	9/2017
Pharmacy and Therapeutics Approval Date	4/2020
Effective Date	6/2020

1. Background:

Nityr (nitisinone) is a hydroxyphenyl-pyruvate dioxygenase inhibitor indicated for the treatment of hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.[1]

Coverage for Nityr will be provided for patients who meet the following criteria:

2. Coverage Criteria:

A. <u>Authorization</u>

1. **Nityr** will be approved based on the following criteria:

   a. Diagnosis of hereditary tyrosinemia type 1

   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. Nityr [package insert]. Cambridge, United Kingdom. Cycle Pharmaceuticals Ltd. November 2018.

Program	Prior Authorization – Nityr (nitisinone) tablets
Change Control	
9/2017	New program
4/2018	Removed all criteria except diagnosis since Nityr will become part of Diagnosis to Drug Match
4/2019	Annual review. Updated reference.
4/2020	Annual review. No changes to criteria.