UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Xuriden

Program	Prior Authorization
Medications	Xuriden™ (uridine triacetate)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	6/2016
Pharmacy and Therapeutics Approval Date	6/2020
Effective Date	8/2020

1. Background:

Xuriden™ (uridine triacetate) is a pyrimidine analog for uridine replacement indicated for the treatment of hereditary orotic aciduria.

2. Coverage Criteria:

A. Initial Authorization

1. **Xuriden** will be approved based on the following criterion:

   a. Diagnosis of a hereditary orotic aciduria

Authorization will be issued for 12 months.

B. Reauthorization

1. **Xuriden** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Xuriden therapy

Authorization will be issued for 12 months.

3. Additional Clinical Programs:

- 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 limitations may be in place

4. References:

1. Xuriden [Prescribing Information]. Wellstat Therapeutics Corp. Gaithersburg, MD. February 2017.

Program	Prior Authorization - Xuriden™ (uridine triacetate)
Change Control	
6/2016	New program.
6/2017	Annual review with no changes to criteria. Updated reference.
6/2018	Annual review with no changes to criteria.
6/2019	Annual review with no changes to criteria.
6/2020	Annual review; added Additional Clinical Programs Section