UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2129-10
Program	Prior Authorization/Medical Necessity
Medication	Ravicti™ (glycerol phenylbutyrate oral liquid)
P&T Approval Date	7/2017, 7/2018, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 2/2024, 2/2025
Effective Date	5/1/2025

1. Background

Ravicti (glycerol phenylbutyrate) is a nitrogen-binding agent indicated for chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone. Ravicti must be used with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements).

Ravicti is not indicated for treatment of acute hyperammonemia in patients with UCDs. The safety and efficacy for treatment in N-acetylglutamate synthase (NAGS) deficiency has not been established. [1]

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

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Ravicti** will be approved based on **all** of the following criteria:

   a. All of the following:

      (1) Patient has a diagnosis of a urea cycle disorder (UCD)

      -AND-

      (2) Patient does not have N-acetylglutamate synthase (NAGS) deficiency

      -AND-

      (3) Patient has history of inadequate response to **one** of the following:

         (a) Dietary protein restriction
         (b) Amino acid supplementation

      -AND-

      (4) **One** of the following:

         (a) **Both** of the following

            i. History of failure to sodium phenylbutyrate (Buphenyl®)

-AND-

ii. Submission of medical records (e.g., chart notes, laboratory values) documenting **one** of the following while on sodium phenylbutyrate

1. Fasting ammonia level > 0.5 ULN

-OR-

2. Any ammonia level [fasting/non-fasting] above the ULN

-OR-

(b) **Both** of the following:

i. History of intolerance to sodium phenylbutyrate oral tablets

-AND-

ii. Submission of medical records (e.g., chart notes, prescription claims history) documenting trial of sodium phenylbutyrate oral tablets

-OR-

(c) Submission of medical records (e.g. chart notes) documenting a contraindication to sodium phenylbutyrate

-OR-

(d) **Both** of the following

i. Patient is currently on Ravicti therapy

-AND-

ii. Patient has not received a manufacturer supplied sample at no cost in prescriber office, or any form of assistance from the Horizon Therapeutics sponsored TranscendRare™ program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Ravicti*

* Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Horizon Therapeutics sponsored TranscendRare™ program shall be required to meet initial authorization criteria as if patient were new to therapy.

-AND-

(5) Will be used concomitantly with dietary protein restriction and, in some cases,

dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

Authorization will be issued for 12 months.

B. <u>Reauthorization</u>

1. **Ravicti** will be approved based on **<u>both</u>** of the following criteria:

   a. Documentation of positive clinical response to Ravicti therapy

   -AND-

   b. Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

   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.

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. Ravicti® [package insert], Lake Forest, IL: Horizon Therapeutics, Inc.; September 2021.
2. Lee B. Urea Cycle Disorders: Management. In: UpToDate, Waltham, MA, 2024. Accessed December 23, 2024
3. Lee B., Diaz GA, Rhead W., et al. Blood ammonia and glutamine as predictors of hyperammonemic crises in patients with urea cycle disorder. Genet Med. 2015; 17(7):561-8.

Program	Prior Authorization/Medical Necessity - Ravicti (glycerol phenylbutyrate oral liquid)
Change Control	
7/2017	New program
7/2018	Annual review. Updated criteria regarding sodium phenylbutyrate intolerance specifying that patient experience intolerance to oral tablets prior to coverage for Ravicti.
12/2018	Administrative change to add statement regarding use of automated processes.
2/2019	Updated background and criteria to align with updated indication allowing use in patients less than 2 months of age.

2/2020	Annual review with no change to clinical coverage. Updated reference.
2/2021	Annual review with no change to clinical coverage. Updated references.
2/2022	Annual review with no change to clinical coverage. Updated references.
2/2023	Annual review with no change to clinical coverage. Updated references.
2/2024	Annual review with no change to clinical coverage.
2/2025	Annual review with no change to clinical coverage. Updated reference.