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)]
Issue Date	9/2014
Pharmacy and Therapeutics Approval Date	10/2017
Effective Date	11/2017

1. Background:

Cuprimine (penicillamine)	**Wilson's Disease** – Indicated in the treatment of Wilson's disease
	Cystinuria – Indicated in the treatment of cystinuria
	Rheumatoid Arthritis – Indicated in the treatment of severe, active rheumatoid arthritis who have failed to respond to an adequate trial of conventional therapy
Depen Titratable (penicillamine)	**Wilson's Disease** – Indicated in the treatment of Wilson's disease
	Cystinuria – Indicated in the treatment of cystinuria
	Rheumatoid Arthritis – Indicated in the treatment of severe, active rheumatoid arthritis who have failed to respond to an adequate trial of conventional therapy
Syprine (trientine)	**Wilson's Disease** – Indicated in the treatment of Wilson's disease who are intolerant of penicillamine

2. Coverage Criteria:

A. <u>Depen Titratable</u>

1. <u>Initial Authorization</u>

a. **<u>One</u>** 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. References:

1. Cuprimine Prescribing Information. Aton Pharma, Inc., November 2015.
2. Syprine Prescribing Information. Aton Pharma, Inc., December 2016.
3. Depen Titratable Prescribing Information. Meda Pharmaceuticals. April 2009.

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