UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Nityr

Program	Prior Authorization
Medication	Nityr™ (nitisinone)
Issue Date	9/2017
Pharmacy and Therapeutics Approval Date	9/2017
Effective Date	11/2017

1. Background:

Nityr 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. Initial Authorization

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

   a. Diagnosis of hereditary tyrosinemia type 1

   AND

   b. Nityr is being used as an adjunct to diet modification.

   Authorization will be issued for 12 months.

B. Reauthorization

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

   a. Patient shows evidence of positive clinical response (e.g. decrease in urinary/plasma succinylacetone and alpha-1-microglobulin levels) while on Nityr therapy

   Authorization will be issued for 12 months.

3. References:

1. Nityr [prescribing information]. Cambridge, United Kingdom. Cycle Pharmaceuticals Ltd. July 2017.

Program	Prior Authorization – Nityr (nitisinone) tablets
Change Control	
9/2017	New program