Pharmacy Medical Necessity Guidelines: Nityr™ and Orfadin® (nitisinone)

Effective: July 1, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Rx	Department to Review	RxUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM:
617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Hereditary tyrosinemia type 1 (HT-1) is a rare genetic metabolic disorder that causes progressive liver disease and renal tubular dysfunction. The disorder is caused by fumarylacetoacetate hydrolase deficiency, the last enzyme in the degradation pathway of the amino acid tyrosine, resulting in the accumulation of toxic metabolites. HT-1 is present at birth and manifests within weeks or months in the failure of the infant to thrive and by symptoms of hepatomegaly, edema, ascites, melena, and hemorrhagic diathesis.

Nityr and Orfandin (nitisinone) inhibit 4-hydroxyphenylpyruvate dioxygenase and prevent the formation of toxic metabolites involved in hepatic and renal lesions. Because these medications inhibit the breakdown of tyrosine which leads to increase plasma levels of tyrosine, patients receiving therapy must restrict their dietary intake of tyrosine and phenylalamine.

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Nityr tablets and Orfadin capsules and or soluation (nitisinone) are indicated for the treatment of HT-1 in combination with dietary restriction of tyrosine and phenylalanine. Orfadin 2, 5, and 10 mg capsules are available generically and are covered without Prior Authorization. Orfadin 10 mg capsules, 4 mg/mL oral solution, and Nitry tablets are nonpreferred.

COVERAGE GUIDELINES

The plan may authorize coverage of Orfadin 20 mg capsule and 4 mg/mL solution or Nityr tablets when the following criterion is met:

1. Documentation of genetic tyrosinemia Type–1 (hereditary tyrosinemia Type-1)

AND

2. Clinical rationale why the Member cannot take nitisinone 2 mg, 5 mg, or 10 mg capsules

LIMITATIONS

1. Orfadin and Nityr (nitisinone) will not be covered for any indication other than tyrosinemia Type-1 (hereditary tyrosinemia Type-1).
2. Requests for brand-name products, which have AB-rated generics, will be also reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Barkaoui E, Debray D, Habes D, et al. Favorable outcome of treatment with NTBC of acute liver insufficiency disclosing hereditary tyrosinemia type I. *Arch Pediatr.* 1999 May;6(5):540-4.
2. Holme E, Lindstedt S. Tyrosinaemia type I and NTBC. *J Inherit Metab Dis*. 1998 Aug;21(5):507-17.
3. Lindblad B, Lindstedt S, Steen G. On the enzymic defects in hereditary tryosinemia. *Proc Natl Acad Sci USA*. 1977 Oct;74(10):4641-5.
4. Nityr (nitisinone) [package insert]. Rivopharm SA: S; November 2018.
5. Orfadin (nitisinone) [package insert]. Apoteket Produktion & Laboratorier AB, Sweden; May 2019.

APPROVAL HISTORY

November 2002: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. August 9, 2005: No changes
2. September 14, 2004: No changes
3. July 11, 2006: No changes
4. July 10, 2007: No changes
5. July 08, 2008: No changes
6. July 14, 2009: No changes
7. January 1, 2010: Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred)
8. July 13, 2010: No changes
9. July 12, 2011: No changes
10. April 10, 2012: No changes
11. March 12, 2013: No changes
12. March 11, 2014: No changes
13. March 10, 2015: No changes
14. January 1, 2016: Administrative change to rebranded template.
15. February 9, 2016: No changes
16. July 12, 2016: No changes
17. April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
18. July 11, 2017: No changes
19. December 12, 2017: Changed the name of the Medical Necessity Guideline to Orfadin and Nityr (nitisinone). Added Nityr (nitisinone) to the Medical Necessity Guideline. Effective 12/18/17, the Medical Necessity Guideline applies to Tufts Health Together and Tufts Health RITogether.
20. December 11, 2018: Administrative update to the template.
21. October 15, 2019: Effective April 1, 2020, brand Orfadin has been moved to non-covered status for all lines of business. No changes to criteria.
22. April 14, 2020: Effective 4/14/20, MNG no longer applies to Commercial and Direct. Updated MNG to indicate that generic Orfadin formulations are covered without PA. Added to the limitations section that requests for brand name agents with AB-rated generics will be reviewed against the Brand Name criteria. Effective July 1, 2020, updated criteria for Orfadin 20 mg capsule, 4 mg/mL oral solution, and Nityr tablets to require clinical rationale why the member cannot take generic nitisinone 2 mg, 5 mg, or 10 mg capsules.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.