Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/01/2022**
Policy Number: PA.CP.PHAR.132	**Effective Date: 10/2018** **Revision Date: 09/2022**
Policy Name: Nitisinone (Nityr, Orfadin)	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ☐ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

4Q 2022 annual review: no significant changes; references reviewed and updated.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Nitisinone (Nityr, Orfadin)

Reference Number: PA.CP.PHAR.132
Effective Date: 10.17.18
Last Review Date: 10/2022

Revision Log

Description
Nitisinone (Nityr™, Orfadin®) is a hydroxy-phenylpyruvate dioxygenase inhibitor.

FDA Approved Indication(s)
Nityr and Orfadin are indicated for the treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Nityr and Orfadin are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hereditary Tyrosinemia Type 1 (must meet all)**:**

1. Diagnosis of HT-1 as confirmed by one of the following (a or b);
   a. Genetic testing confirms a mutation of the *FAH* gene;
   b. Biochemical testing confirms elevated levels of succinylacetone in blood or urine;*

   * *The lower limit of normal for succinylacetone is laboratory- and/or treatment center-specific; refer to laboratory- or clinic-specific reference ranges to determine elevated levels.*
2. Prescribed by or in consultation with an endocrinologist or a metabolic or genetic disease specialist;
3. Request is for use as an adjunct to dietary restriction of tyrosine and phenylalanine;
4. Dose does not exceed 2 mg/kg per day.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

II. Continued Therapy

A. Hereditary Tyrosinemia Type 1 (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. Request is for use as an adjunct to dietary restriction of tyrosine and phenylalanine;

4. If request is for a dose increase, new dose does not exceed 2 mg/kg per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria or the Continuity of Care Policy (PA.LTSS.PHAR.01) applies.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – PA.CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HT-1: hereditary tyrosinemia type 1

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Box warning(s): none reported

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Nitisinone (Nityr)	0.5 mg/kg PO BID	2 mg/kg
Nitisinone (Orfadin)	0.5 mg/kg PO BID	2 mg/kg

VI. Product Availability

Drug Name	Availability
Nitisinone (Nityr)	Tablets: 2 mg, 5 mg, 10 mg
Nitisinone (Orfadin)	Capsules: 2 mg, 5 mg, 10 mg, 20 mg Oral suspension: 4 mg/mL

VII. References

1. Orfadin Prescribing Information. Waltham, MA: Sobi, Inc.; November 2021. Available at: http://www.orfadin.com/. Accessed August 27, 2022.
2. Nityr Prescribing Information. Centro Insema, Manno Switzerland: Rivopharm; June 2021. Available at: www.nityr.us. Accessed August 27, 2022.

3. Chinsky JM, Singh R, Ficicioglu C, et al. Diagnosis and treatment of tyrosinemia type I: a US and Canadian consensus group review and recommendations. Genetics in Medicine. Dec 2017;19(12).

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10/2018	
4Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020	10/2019	
4Q 2020 annual review: added requirement for adjunctive dietary restriction of tyrosine and phenylalanine, in line with the FDA-approved indication; references reviewed and updated.	10/2020	
4Q 2021 annual review: added requirement for diagnosis confirmation by either genetic or biochemical testing; references reviewed and updated.	10/2021	
4Q 2022 annual review: no significant changes; references reviewed and updated.	10/2022	