

# Specialty Guideline Management nitisinone-Nityr-Orfadin

#### **Products Referenced by this Document**

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Nityr	nitisinone
Orfadin	nitisinone

# Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

#### FDA-approved Indications<sup>1-3</sup>

Nityr/Orfadin/nitisinone is 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.

All other indications are considered experimental/investigational and not medically necessary.

# Documentation

Submission of the following information is necessary to initiate the prior authorization review: biochemical testing, enzyme assay, or genetic testing results supporting diagnosis.

CF\_RxCriteria\_ORFADIN\_2120-A.docx

© 2025 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.

## **Prescriber Specialties**

This medication must be prescribed by or in consultation with a physician who specializes in the treatment of enzyme or metabolic disorders.

## **Coverage Criteria**<sup>1-3</sup>

#### Hereditary Tyrosinemia Type 1 (HT-1)

Authorization of 12 months may be granted for treatment of hereditary tyrosinemia type 1 (HT-1) when the diagnosis is confirmed by biochemical testing (e.g., detection of succinylacetone in urine), enzyme assay, or genetic testing and the requested medication is being used as an adjunct to dietary restriction of tyrosine and phenylalanine.

# **Continuation of Therapy**

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section who are experiencing beneficial clinical response from therapy.

#### References

- 1. Orfadin [package insert]. Waltham, MA: Sobi, Inc; November 2021.
- 2. Nityr [package insert]. Cambridge, United Kingdom: Cycle Pharmaceuticals Ltd.; May 2024.
- 3. nitisinone [package insert]. Chestnut Ridge, NY: Par Pharmaceutical; October 2019.

CF\_RxCriteria\_ORFADIN\_2120-A.docx

© 2025 CVS Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.