Reference number(s)
3253-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☐
Standard Control – Choice (SCCF)	☐
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☑
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☑
Value Formulary Chart (VFC)	☑
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Cystinosis

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Advanced Control Specialty Formulary (ACSF), Choice Formulary (ACSCF), Value Formulary (VF), Managed Medicaid Template (MMT), Advanced Control Specialty Formulary Chart (ACSFC), and Value Formulary Chart (VFC).

Plan Design Summary

This program applies to the cystinosis products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with the targeted product.

Each referral is reviewed based on all utilization management (UsM) programs implemented for the client.

Table. Cystinosis Agents

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred*	• **Cystagon** (cysteamine bitartrate)
Target	• **Procysbi** (cysteamine bitartrate)

Reference number(s)
3253-D

.Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for the targeted product is provided when the member has a documented intolerable adverse event with the preferred product.

References

1. Procysbi [package insert]. Deerfield, IL: Horizon Pharma USA, Inc.; February 2022.
2. Cystagon [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; August 2021.