Pharmacy Drug Policy Checklist

POLICY NAME	Orfadin, Nityr, and nitisinone	POLICY #	2450P

Criteria

Coverage Criteria for Hereditary Tyrosinemia type 1

- ☐ **1.1** Diagnosis of hereditary tyrosinemia type 1 confirmed by diagnostic/DNA testing
- ☐ **1.2** Orfadin or Nityr will be used in addition to dietary restriction of tyrosine and phenylalanine
- ☐ **1.3** Coverage of Orfadin capsules requires previous trial with equivalent generic nitisinone capsules

Approval Time

- ☐ **2.1** Initial: 12 months
- ☐ **2.2** Reapproval: 12 months if
  - Dietary restrictions of tyrosine and phenylalanine are continued
  - Member is compliant with Orfadin or Nityr regimen CPT Codes HCPCS Codes