

Urea Cycle Disorders Prior Authorization Program Summary

POLICY REVIEW CYCLE

Effective Date
12-15-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Ravicti	glycerol phenylbutyrate liquid	1.1 GM/ML	M ; N ; O ; Y	O ; Y		
Buphenyl ; Olpruva ; Pheburane	sodium phenylbutyrate oral pellets ; sodium phenylbutyrate oral powder ; sodium phenylbutyrate packet for susp ; sodium phenylbutyrate tab	2 GM ; 3 GM ; 3 GM/TSP ; 4 GM ; 483 MG/GM ; 5 GM ; 500 MG ; 6 GM ; 6.67 GM	M ; N ; O ; Y	N ; O ; Y		

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Buphenyl ; Olpruva ; Pheburane	sodium phenylbutyrate oral pellets ; sodium phenylbutyrate oral powder ; sodium phenylbutyrate packet for susp ; sodium phenylbutyrate tab	2 GM ; 3 GM ; 3 GM/TSP ; 4 GM ; 483 MG/GM ; 5 GM ; 500 MG ; 6 GM ; 6.67 GM	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Ravicti	glycerol phenylbutyrate liquid	1.1 GM/ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

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	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of hyperammonemia AND ALL of the following: <ol style="list-style-type: none"> A. The patient has elevated ammonia levels according to the patient's age (Neonate: plasma ammonia level 150 micromol/L [greater than 260 micrograms/dL] or higher; Older child or adult: plasma ammonia level greater than 100 micromol/L [175 micrograms/dL]) AND B. The patient has a normal anion gap AND C. The patient has a normal blood glucose level AND 2. The patient has a diagnosis of ONE of the following urea cycle disorders confirmed by enzyme analysis OR genetic testing: <ol style="list-style-type: none"> A. Carbamoyl phosphate synthetase I deficiency (CPSID) OR B. Ornithine transcarbamylase deficiency (OTCD) OR C. Argininosuccinic acid synthetase deficiency (ASSD) OR D. Argininosuccinic acid lyase deficiency (ASLD) OR E. Arginase deficiency (ARG1D) AND 3. The requested agent will NOT be used as treatment of acute hyperammonemia AND 4. The patient is unable to maintain a plasma ammonia level within the normal range with the use of a protein restricted diet and, when clinically appropriate, essential amino acid supplementation AND 5. The patient will be using the requested agent as adjunctive therapy to dietary protein restriction AND 6. ONE of the following: <ol style="list-style-type: none"> A. If the requested agent is Buphenyl or Olpruva, then ONE of the following: <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes required] OR 3. The patient has tried and had an inadequate response to generic sodium phenylbutyrate [chart notes required] OR 4. Generic sodium phenylbutyrate was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR 5. The patient has an intolerance or hypersensitivity to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent [chart notes required] OR 6. The patient has an FDA labeled contraindication to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent [chart notes required] OR 7. Generic sodium phenylbutyrate is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes required] OR 8. Generic sodium phenylbutyrate is not in the best interest of the patient based on medical necessity [chart notes required] OR 9. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic

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	<p>sodium phenylbutyrate and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR</p> <p>10. There is support for the use of the requested brand agent over generic sodium phenylbutyrate OR</p> <p>B. If the requested agent is Ravicti or glycerol phenylbutyrate, then ONE of the following:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes required] OR 3. The patient has tried and had an inadequate response to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 4. Generic sodium phenylbutyrate AND Pheburane was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR 5. The patient has an intolerance or hypersensitivity to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 6. The patient has an FDA labeled contraindication to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 7. Generic sodium phenylbutyrate AND Pheburane are expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes required] OR 8. Generic sodium phenylbutyrate AND Pheburane are not in the best interest of the patient based on medical necessity [chart notes required] OR 9. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sodium phenylbutyrate AND Pheburane and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] 10. There is support for the use of the requested brand agent over generic sodium phenylbutyrate AND Pheburane AND <p>7. The prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic disorders), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND</p> <p>8. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>9. The requested quantity (dose) is within FDA labeled dosing for the requested indication</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND

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	<p>B. ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan’s Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient has had clinical benefit with the requested agent AND 3. The requested agent will NOT be used as treatment of acute hyperammonemia AND 4. The patient will be using the requested agent as adjunctive therapy to dietary protein restriction AND 5. ONE of the following: <ol style="list-style-type: none"> A. If the requested agent is Buphenyl or Olpruva, then ONE of the following: <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes required] OR 3. The patient has tried and had an inadequate response to generic sodium phenylbutyrate [chart notes required] OR 4. Generic sodium phenylbutyrate was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR 5. The patient has an intolerance or hypersensitivity to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent [chart notes required] OR 6. The patient has an FDA labeled contraindication to generic sodium phenylbutyrate that is NOT expected to occur with the requested brand agent [chart notes required] OR 7. Generic sodium phenylbutyrate is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient’s

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	<p>adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes required] OR</p> <ol style="list-style-type: none"> 8. Generic sodium phenylbutyrate is not in the best interest of the patient based on medical necessity [chart notes required] OR 9. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sodium phenylbutyrate and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR 10. There is support for the use of the requested brand agent over generic sodium phenylbutyrate OR <p>B. If the requested agent is Ravicti or glycerol phenylbutyrate, then ONE of the following:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR 2. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes required] OR 3. The patient has tried and had an inadequate response to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 4. Generic sodium phenylbutyrate AND Pheburane was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR 5. The patient has an intolerance or hypersensitivity to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 6. The patient has an FDA labeled contraindication to generic sodium phenylbutyrate AND Pheburane [chart notes required] OR 7. Generic sodium phenylbutyrate AND Pheburane are expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes required] OR 8. Generic sodium phenylbutyrate AND Pheburane are not in the best interest of the patient based on medical necessity [chart notes required] OR 9. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic sodium phenylbutyrate AND Pheburane and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] 10. There is support for the use of the requested brand agent over generic sodium phenylbutyrate AND Pheburane AND <ol style="list-style-type: none"> 6. The prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic disorders), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 7. The patient does NOT have any FDA labeled contraindications to the requested agent AND 8. The requested quantity (dose) is within FDA labeled dosing for the requested indication <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

