HealthPartners®

Depen (penicillamine)

Severe Homozygous Cystinuria Coverage Criteria:

1. Patient is diagnosed with severe homozygous Cystinuria; and,
2. Prescribed by a nephrologist; and,
3. Urinary cystine greater than 500 mg/day after treatment with all of the following conservative measures:
    a. high fluid intake; and,
    b. alkali and diet modification; and,
    c. potassium citrate; and,
    d. captopril; and,
4. The patient and/or guardian has attested that they will adhere to the treatment plan; and,
5. Patient has a documented allergic reaction to the generic equivalent; and,
6. When prescribed according to the FDA approved regimen.

Coverage Duration:

Initial authorization will be provided for 6 months
Reauthorization will be provided for 12 months

Reauthorization Criteria:

1. Patient has been seen by the prescriber in the past 12 months; and,
2. Patient has demonstrated benefit from therapy by a reduction in cysteine levels in the urine; and,
3. Prescribed according to the FDA approved regimen.

Wilson's Disease Coverage Criteria

1. Patient is diagnosed with Wilson's Disease; and,
2. Prescribed by a hepatologist; and,
3. The patient and/or guardian has attested that they will adhere to the treatment plan; and,
4. Patient has a documented allergic reaction to the generic equivalent; and,
5. When prescribed according to the FDA approved regimen.

Brand name drugs for which there is an equivalent generic are reserved for patients with a documented allergic reaction to the equivalent generic. Patients must meet all other coverage criteria.

Coverage Duration:

Initial authorization will be provided for 6 months
Reauthorization will be provided for 12 months

Reauthorization Criteria:

1. Patient has been seen by the prescriber in the past 12 months; and,
2. Patient has demonstrated benefit from therapy by a reduction in free serum copper levels; and,
3. Prescribed according to the FDA approved regimen.