

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1401-5
Program	Prior Authorization/Notification
Medication	Cuvrior™ (trientine tetrahydrochloride)*
P&T Approval Date	1/2023, 1/2024, 2/2024, 2/2025, 2/2026
Effective Date	5/1/2026

1. Background:

Cuvrior* (trientine tetrahydrochloride) is a copper chelator indicated for the treatment of adult patients with Wilson’s disease who are de-coppered and tolerant to penicillamine.

2. Coverage Criteria^a:

A. Initial Authorization

1. **Cuvrior*** will be approved based on **all** of the following criteria:

a. Diagnosis of Wilson’s disease

-AND-

b. Patient is de-coppered [i.e., serum non-ceruloplasmin copper (NCC) level ≥ 25 and ≤ 150 mcg/L]

-AND-

c. Patient is tolerant to penicillamine

-AND-

d. Patient will discontinue penicillamine before starting therapy with Cuvrior

Authorization will be issued for 12 months.

B. Reauthorization

1. **Cuvrior*** will be approved based upon the following criterion:

a. Documentation of positive clinical response to Cuvrior therapy

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

*Cuvrior is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Cuvrior [package insert]. Chicago, IL: Orphalan; April 2022.

Program	Prior Authorization/Notification – Cuvrior (trientine tetrahydrochloride)
Change Control	
1/2023	New program.
1/2024	Annual review with no changes to coverage criteria.
2/2024	Annual review. Added footnote indicating Cuvrior is typically excluded from coverage. Updated authorization durations to 12 months.
2/2025	Annual review with no changes to coverage criteria.
2/2026	Annual review with no changes.