UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1515-1
Program	Prior Authorization/Notification
Medication	Zycubo® (copper histidinate)
P&T Approval Date	3/2026
Effective Date	6/1/2026

1. Background:

Zycubo® (copper histidinate) is a copper replacement product indicated for the treatment of Menkes disease in pediatric patients.

Limitations of Use:
Zycubo is not indicated for the treatment of Occipital Horn Syndrome.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Zycubo** will be approved based on **both** of the following criteria:

   a. Diagnosis of Menkes disease

   -AND-

   b. Patient is < 18 years old

   Authorization will be issued for 12 months.

B. Reauthorization

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

   a. Documentation of positive clinical response to Zycubo 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.

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. Zycubo [package insert]. Solana Beach, CA: Sentynl Therapeutics, Inc.; January 2026.

Program	Prior Authorization/Notification – Zycubo (copper histidinate)
Change Control	
3/2026	New program.