Louisiana Medicaid
Penicillamine (Cuprimine®, Depen®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for penicillamine (Cuprimine®, Depen®).

Additional Point-of-Sale edits may apply.

Approval Criteria

- The recipient has a diagnosis of:
    - Wilson's Disease; **OR**
    - Cystinuria and the following information is **stated on the request**:
        - the recipient has a history of failure, contraindication, or intolerance to conservative treatment measures [e.g. use of urinary alkalinization such as potassium citrate, high fluid intake, sodium and protein restriction] (drug names, dates of usage, and other details are documented on request); **OR**
    - Rheumatoid Arthritis and the following information is **stated on the request**:
        - the recipient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of at least one non-biologic DMARD (such as methotrexate, leflunomide, or azathioprine); **AND**
- The prescriber is (or has consulted with) a gastroenterologist, hepatologist, rheumatologist, or liver transplant physician; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, recommended concurrent drug therapies, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of penicillamine and the recipient will not receive penicillamine in combination with any medication that is contraindicated or not recommended per FDA labeling; **AND**
    - Women of childbearing age have had a negative pregnancy test within 30 days prior to therapy initiation for the treatment of rheumatoid arthritis.

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber states on the request that there is evidence of a positive response to treatment as indicated by **stating ONE** of the following **on the request**:
    - There has been improvement in neurologic condition or improved liver findings in the treatment of Wilson's disease; **OR**
    - There are decreased concentrations of urinary cysteine or decreased kidney stone frequency or severity in the treatment of cystinuria; **OR**

- There has been improvement in patient-reported symptoms and/or physical examination findings compared to baseline, improved laboratory values, or reduced dosage of corticosteroids in the treatment of rheumatoid arthritis.

Duration of initial authorization approval: 6 months

Duration of reauthorization approval: 1 year

References

Cuprimine (penicillamine) [package insert]. Bridgewater, NJ: Aton Pharma; September 2018 https://www.bauschhealth.com/Portals/25/Pdf/PI/Cuprimine-PI.pdf

Depen (penicillamine) [package insert]. Somerset, NJ: Meda Pharmaceuticals Inc; January 2019 https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=38f8ae60-b354-11de-8a39-0800200c9a66&type=display

Revision	Date
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