

**Clinical Policy: Sapropterin Dihydrochloride (Kuvan, Javygtor)**

Reference Number: CP.PHAR.43

Effective Date: 02.01.10

Last Review Date: 05.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Sapropterin dihydrochloride (Kuvan<sup>®</sup>) is a synthetic form of tetrahydrobiopterin (BH4), the cofactor for the enzyme phenylalanine hydroxylase.

**FDA Approved Indication(s)**

Kuvan is indicated to reduce blood phenylalanine (Phe) levels in adult and pediatric patients one month of age and older with hyperphenylalaninemia (HPA) due to tetrahydrobiopterin- (BH4-) responsive phenylketonuria (PKU). Kuvan is to be used in conjunction with a Phe-restricted diet.

**Policy/Criteria**

*Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Kuvan and sapropterin formulations are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Phenylketonuria (must meet all):**

1. Diagnosis of HPA due to PKU;
2. Prescribed by or in consultation with a metabolic or genetic disease specialist;
3. Recent (within 90 days) Phe blood level is > 360 µmols/L;
4. Member is currently on a Phe-restricted diet and will continue this diet during treatment with sapropterin;
5. Sapropterin is not prescribed concurrently with Palynziq<sup>®</sup>;
6. If request is for brand Kuvan or Javygtor, member must use generic sapropterin, unless contraindicated or clinically significant adverse effects are experienced;
7. Documentation of member's current weight (in kg);
8. Dose does not exceed 20 mg/kg per day.

**Approval duration: 6 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

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- CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

### A. Phenylketonuria (must meet all):

- 1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
- 2. Member is responding positively to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy;
- 3. Member is currently on a Phe-restricted diet and will continue this diet during treatment with Kuvan;
- 4. If request is for brand Kuvan or Javygtor, member must use generic sapropterin, unless contraindicated or clinically significant adverse effects are experienced;
- 5. Sapropterin is not prescribed concurrently with Palynziq;
- 6. Documentation of member's current weight (in kg);
- 7. If request is for a dose increase, new dose does not exceed 20 mg/kg per day.

### **Approval duration: 12 months**

### B. Other diagnoses/indications (must meet 1 or 2):

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
- 2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

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criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM. PA.154 for health insurance marketplace, CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

BH4: tetrahydrobiopterin	Phe: phenylalanine
FDA: Food and Drug Administration	PKU: phenylketonuria
HPA: hyperphenylalaninemia	

*Appendix B: Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

- According to the Prescribing Information, if a 10 mg/kg per day starting dose is used, then response to therapy is determined by change in blood Phe following treatment with Kuvan at 10 mg/kg per day for a period of up to 1 month. Blood Phe levels should be checked after 1 week of Kuvan treatment and periodically for up to a month. If blood Phe does not decrease from baseline at 10 mg/kg per day, the dose may be increased to 20 mg/kg per day. Additionally, regardless of starting dose, patients whose blood Phe does not decrease after 1 month of treatment at 20 mg/kg per day are non-responders and treatment with Kuvan should be discontinued in these patients.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
BH4-responsive	Age 1 month to ≤ 6 years (starting dose) 10 mg/kg PO QD	20 mg/kg/day
PKU	Age ≥ 7 years (starting dose): 10 to 20 mg/kg PO QD	

**VI. Product Availability**

- Tablet: 100 mg
- Powder for oral solution: 100 mg, 500 mg

**VII. References**

1. Kuvan Prescribing Information. Novato, CA: BioMarin Pharmaceutical, Inc.; August 2024. Available at [www.Kuvan.com](http://www.Kuvan.com). Accessed January 14, 2025.

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2. Levy HL, Milanowski A, Chakrapani A, et. Al. Efficacy of sapropterin dihydrochloride (tetrahydrobiopterin, 6R-BH4) for reduction of phenylalanine concentration in patients with phenylketonuria: a phase III randomized placebo-controlled study. *Lancet*. 2007;370(9586):504.
3. Vockly J, Andersson HC, Antshel KM, et al. ACMG practice guidelines: phenylalanine hydroxylase deficiency: diagnosis and management guideline. *Genet Med*. 2014;16(2):188-200.
4. Camp KM, Parisi MA, Acosta PB, et al. Phenylketonuria scientific review conference: state of the science and future research needs. *Mol Genet Metab*. June 2014;112(2):87-122.
5. van Spronsen FJ. Mild hyperphenylalaninemia: to treat or not to treat. *J Inherit Metab Dis*. 2011;34:651-656.
6. Smith WE, Berry SA, Bloom K, et al. Phenylalanine hydroxylase deficiency diagnosis and management: a 2023 evidence-based clinical guideline of the American College of Medical Genetics and Genomics (ACMG). *Genetics in Medicine*. 2024;27(1):101289. doi: <https://doi.org/10.1016/j.gim.2024.101289>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.28.20	02.21
2Q 2021 annual review: to align with the previously Corporate-approved approach for the treatment of PKU, added requirements for a Phe-restricted diet and excluded coverage of concurrent use of Kuvan and Palynziq; references reviewed and updated.	02.28.21	05.21
2Q 2022 annual review: no significant changes; added redirection to generic product for brand requests; references reviewed and updated.	02.27.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	11.23.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.09.23	05.23
2Q 2024 annual review: increased initial auth duration to align with those of other drugs for rare diseases; for Continued Therapy added exclusion for concomitant use with Palynziq to match with the Initial Approval Criteria; references reviewed and updated.	02.29.24	05.24
2Q 2025 annual review: no significant changes; added requirement for a redirection from Javygtor (branded generic) to unbranded generic sapropterin per an SDC recommendation; added a requirement for documentation of member’s current weight for dose calculation purposes; references reviewed and updated.	03.10.25	05.25

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted

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standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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