UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1400-2
Program	Prior Authorization/Notification
Medication	Relyvrio® (sodium phenylbutyrate and taurursodiol)
P&T Approval Date	12/2022, 12/2023
Effective Date	3/1/2024

1. Background:
Relyvrio is indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults.[1]

2. Coverage Criteria[a]:

A. Initial Authorization

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

   a. Diagnosis of amyotrophic lateral sclerosis (ALS)

   Authorization will be issued for 6 months.

B. Reauthorization

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

   a. Documentation of positive clinical response to **Relyvrio** therapy.

   Authorization will be issued for 6 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. Relyvrio [package insert]. Cambridge, MA: Amylyx Pharmaceuticals, Inc. September 2022.

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Change Control	
12/2022	New program.
12/2023	Annual review without changes to clinical coverage criteria.