Drug Coverage Policy

Effective Date 8/15/2026
Coverage Policy Number.....IP0046
Policy Title.....Cysteamine (Oral) Products for Employer Plans

Metabolic Disorders – Cysteamine (Oral) Products for Employer Plans

- Procysbi® (cysteamine bitartrate delayed-release capsules, delayed release granules – Horizon)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW
Cystagon and Procysbi are cystine-depleting agents indicated for the management of **nephropathic cystinosis**.[1-2] Note that Procysbi is indicated specifically in patients who are ≥ 1 year of age, whereas there is not an age limit for pediatric use of Cystagon.

Therapy with a cysteamine product should be initiated promptly once the diagnosis is confirmed (i.e., increased white blood cell cystine concentration).

Disease Overview
Cystinosis is a very rare autosomal recessive inborn error of metabolism in which cystine accumulates within lysosomes and forms crystals in many tissues, including the kidneys, liver, bone marrow, pancreas, muscle, rectal mucosa, brain, and eye.[3,4] Patients with cystinosis also experience growth failure and rickets, and cystine deposits in the cornea cause photophobia. Over time, most organs are damaged. Diagnosis is confirmed by measuring cystine levels in polymorphonuclear leukocytes.[5] Molecular genetic testing identifies a characteristic mutation of the *CTNS* gene.

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POLICY STATEMENT
Prior Authorization is required for benefit coverage of Procysbi All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Procysbi as well as the monitoring required for adverse events and long-term efficacy, initial approval requires the agent to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information.

Procysbi is considered medically necessary when the following is met:

FDA-Approved Indication

1. **Cystinosis, Nephropathic.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D and E):
   - **A)** Patient is ≥ 1 year of age; AND
   - **B)** According to the prescriber, diagnosis was confirmed by ONE of the following (i or ii):
     - **i.** Genetic testing confirmed biallelic pathogenic or likely pathogenic variants in the *CTNS* gene **[documentation required]**; OR
     - **ii.** White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory **[documentation required]**; AND
       Note: The methods used for measuring cystine vary among individual laboratories and depend upon the assay method used by the individual laboratory; values obtained from using different assay methods may not be interchangeable.
   - **C)** Patient will not be using Cystagon and Procysbi concurrently; AND
   - **D)** The medication is prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases).
   - **E)** Preferred product criteria is met for the product(s) as listed in the below table(s)

Employer Group:

Product	Criteria
Procysbi (cysteamine bitartrate delayed-release capsules or granules)	Patient has tried, and according to the prescriber, the patient has had inadequate efficacy or significant intolerance to Cystagon (cysteamine bitartrate capsules) **[documentation required]**

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Procysbi for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Therapy with Cystagon and Procysbi.** There are no data available to support concomitant use.

References

1. Procysbi® [prescribing information]. Lake Forest, IL: Horizon; February 2022.
2. Cystagon® [prescribing information]. Morgantown, WV: Mylan; August 2021.
3. Wilmer MJ, Schoeber JP, van den Heuvel LP, Levtchenko EN. Cystinosis: practical tools for diagnosis and treatment. *Pediatr Nephrol*. 2011; 26(2): 205–215.
4. Elmonem MA, Veys KR, Soliman NA, et al. Cystinosis: a review. *Orphanet J Rare Dis*. 2016 Apr 22;11:47.
5. National Organization for Rare Disorders (NORD). Cystinosis. Accessed on July 28, 2026. Available at: https://rarediseases.org/rare-diseases/cystinosis/.

Revision Details

Summary of Changes	Review Date	Effective Date
Cystinosis, Nephropathic. **Added** requirement that patient is ≥ 1 year of age. **Updated** confirmation of a genetic mutation in the *CTNS* gene to more specifically state, "genetic testing confirmed biallelic pathogenic or likely pathogenic variants in the *CTNS* gene."	6/20/2024	8/15/2024
Policy Title: Added "for Employer Plans" to policy title. **Added** documentation requirements.	7/2/2025	8/15/2025
No criteria changes.	7/30/2026	8/15/2026

The policy effective date is in force until updated or retired.

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