HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PRIMARY HYPEROXALURIA TYPE 1

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1500

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Oxlumo™ (lumasiran), ☐ Rivfloza™ (nedosiran)
Please note: the preferred medication will be determined based on Medical Necessity Assessment

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a physician who specializes in the treatment of primary hyperoxaluria type 1 (PH1)?	☐	☐	
2. Does the member have a diagnosis of PH1 confirmed by both of the following: • Metabolic testing shows elevated urinary oxalate excretion persistently > 0.7mmol/1.73m^2/day OR for those less than 6 years of age a urinary oxalate/serum creatinine ratio > the ULN for the member's age • Genetic testing confirms a mutation in the alanine glyoxylate aminotransferase (AGXT) gene	☐	☐	**Please provide documentation**
3. Has the member received a liver transplant?	☐	☐	
4. Does the member have an estimated glomerular filtration rate (eGFR) > 30mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Has the prescriber educated the member about diet, such as avoiding oxalate rich foods (e.g. chocolate, leafy green vegetables, black teas, nuts, star fruit)?	☐	☐	**Please provide documentation**
6. Has the member tried and failed, or has a contraindication/intolerance to, large fluid intake resulting in a high urinary output (> 3 L/day/1.73m^2)?	☐	☐	**Please provide documentation**

7. Has the member tried and failed, is currently taking, or has a contraindication/intolerance to, calcium-oxalate crystallization inhibitors (e.g. potassium citrate-citric acid, orthophosphate, magnesium oxide)?	☐	☐	**Please provide documentation**
8. Has the member tried and failed, is currently taking, or has a contraindication/intolerance to, pyridoxine (Vitamin B6) for ≥ 3 months without a positive response (defined as a reduction of > 30% in urinary oxalate excretion)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive response to therapy with a significant reduction from baseline in urinary oxalate levels or for those <6 years of age a decrease in urinary oxalate/serum creatinine ratio?	☐	☐	**Please provide documentation**
3. Has the member experienced unacceptable drug toxicity to therapy?	☐	☐	
4. Has the member received a liver transplant?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy PHARM-M035
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Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024