Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Oxlumo
(lumasiran)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Oxlumo 94.5 mg/0.5ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:
What is the patient's body weight?

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ PANTHERx
☐ Retail pharmacy
☐ Other (please specify):
☐ Hospital Outpatient
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test results, etc.) be attached with this request****
Will the patient use the requested drug concurrently with Rivfloza (nedosiran subcutaneous injection)? ☐ Yes ☐ No

What is the indication or diagnosis?
☐ Primary Hyperoxaluria Type 1 (PH1)
☐ Primary Hyperoxaluria Type 2 (PH2)
☐ Primary Hyperoxaluria Type 3 (PH3)
☐ Other

Is this initial therapy or is the patient currently receiving Oxlumo?
☐ Initial Therapy
☐ Currently Receiving Oxlumo

(if Initial Therapy) Is documentation being provided to confirm that the patient had a genetic test confirming the diagnosis of Primary Hyperoxaluria Type 1 via identification of biallelic pathogenic variants in the alanine: glyoxylate aminotransferase gene (AGXT)? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Oxlumo Utilization Management Medical Policy through the Coverage Review Department, and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Oxlumo therapy. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if Initial Therapy) Is documentation being provided to confirm that the patient has urinary oxalate excretion greater than or equal to 0.5 mmol/24 hours/1.73 m2 with the absence of secondary sources of oxalate? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Oxlumo Utilization Management Medical Policy through the Coverage Review Department, and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Oxlumo therapy. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided to confirm that the patient has a urinary oxalate: creatinine ratio above the age-specific upper limit of normal? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Oxlumo Utilization Management Medical Policy through the Coverage Review Department, and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Oxlumo therapy. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided to confirm that the patient has a plasma oxalate level greater than or equal to 20 micromoles/L? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Oxlumo Utilization Management Medical Policy through the Coverage Review Department, and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Oxlumo therapy. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(If Initial Therapy) Has the patient previously received a liver transplant for Primary Hyperoxaluria Type 1? ☐ Yes ☐ No

(if Initial Therapy) Is the requested medication being prescribed by or in consultation with a nephrologist or urologist? ☐ Yes ☐ No

(if Currently Receiving Oxlumo) Is documentation being provided to confirm that the patient is continuing to derive benefit from Oxlumo according to the prescriber? Please Note: Examples of responses to Oxlumo therapy are reduced urinary oxalate excretion, decreased urinary oxalate: creatinine ratio, or reduced plasma oxalate levels from baseline (that is, prior to Oxlumo therapy) or improved or stabilized clinical signs/symptoms of Primary Hyperoxaluria Type 1 (for example, nephrocalcinosis, formation of renal stones, renal impairment). PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Oxlumo Utilization Management Medical Policy through the Coverage Review Department, and who is requesting reauthorization, are NOT required to resubmit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Oxlumo therapy. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if Currently Receiving Oxlumo) Has the patient previously received a liver transplant for Primary Hyperoxaluria Type 1? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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