PRIOR AUTHORIZATION REQUEST

Rivfloza

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
2	Has the patient been receiving medication samples of Rivfloza? [If yes, skip to question 7.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for Rivfloza? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

4	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Is the requested medication prescribed by or in consultation with a nephrologist, urologist, or specialist with expertise in the treatment of primary hyperoxaluria? [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Primary hyperoxaluria Type 1 (If checked, go to 8) [] Other (If checked, no further questions)		
8	Has documentation been submitted to confirm the diagnosis with genetic testing of a confirmed mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or a liver enzyme analysis demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the patient 9 years of age or older? [If no, no further questions.]	Yes	No
10	Does the patient have preserved kidney function with an estimated glomerular filtration rate of at least 30 mL/min (eGFR greater than or equal to 30 mL/min/1.73 m2)? [If no, no further questions.]	Yes	No
11	Has the patient received a kidney or liver transplant? [If yes, no further questions.]	Yes	No
12	Has documentation been submitted to show that the patient has a urinary oxalate excretion greater than or equal to 0.7 mmol/24 hours/1.73 m2 in age less than 18 years based on at least 2 assessments? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 15.]	Yes	No
13	Has documentation been submitted to show that the patient has a spot urinary oxalate: creatinine ratio above the age specific upper limit of normal? ACTION REQUIRED: Submit lab reference range. [If yes, skip to question 15.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

14	Has documentation been submitted to show an elevated plasma oxalate concentration greater than the upper limit of normal? ACTION REQUIRED: Submit lab reference range. [If no, no further questions.]	Yes	No
15	Will the patient be taking the requested medication in combination with Oxlumo? [If yes, no further questions.]	Yes	No
16	Has documentation been submitted to show that the patient had a trial and failure (of at least 3 months) on optimal dose, intolerance to, or contraindication to pyridoxine? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Is the patient inadequately managed with increased fluid intake (hyperhydration)? [If no, no further questions.]	Yes	No
18	Is the requested medication prescribed by or in consultation with a nephrologist, urologist, or specialist with expertise in the treatment of primary hyperoxaluria? [If no, no further questions.]	Yes	No
19	Is the dosing within the Food and Drug Administration (FDA) approved labeling?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250