# SENTARA COMMUNITY PLAN
# (MEDICAID)

## MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

**Drug Requested: Rivfloza™** (nedosiran) **(J3490) (Medical)**

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

## Recommended Dosage:

| **Rivfloza - Recommended dosage is shown below and is administered subcutaneously once monthly** | | | |
|---|---|---|---|
| **Age** | **Body Weight** | | |
| | **Less than 39 kg** | **39 kg to less than 50 kg** | **50 kg and above** |
| Age 2 to less than 12 years | 3.3 mg/kg | 128 mg | 160 mg |
| Age 12 years and older | 128 mg | | 160 mg |

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## Max Units (per dose and over time) [HCPS Unit]:

- **Rivfloza 80 mg vial:** 2 vials per month
- **Rivfloza 128 mg prefilled syringe:** 1 syringe per month
- **Rivfloza 160 mg prefilled syringe:** 1 syringe per month

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial Authorization: 6 months**

- ❑ Must be prescribed by or in consultation with a geneticist, nephrologist or urologist
- ❑ Member is 2 years of age or older
- ❑ Member has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following: **(must submit documentation)**
  - ❑ Member has a biallelic pathogenic mutation in the alanine: glyoxylate aminotransferase (AGXT) gene as identified on molecular genetic testing
  - ❑ Identification of alanine: glyoxylate aminotransferase (AGT) enzyme deficiency on liver biopsy
- ❑ Member has a baseline for one or more of the following: **(must submit lab documentation)**:
  - ❑ Urinary oxalate excretion level (corrected for BSA)
  - ❑ Spot urinary oxalate: creatinine ratio
  - ❑ Estimated glomerular filtration rate (eGFR)
  - ❑ Plasma oxalate level
- ❑ Member does NOT have renal impairment defined as an estimated glomerular filtration rate (eGFR) less than 30 ml/min/1.73 $m^2$
- ❑ Member has NOT received a kidney or liver transplant
- ❑ Prescriber attest that Rivfloza will not be used in combination with other urinary oxalate reducing agents (e.g., lumasiran)

**Reauthorization: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet the relevant criteria identified in the initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment

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**Medication being provided by (check applicable box(es) below):**

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****



***Approved by Pharmacy and Therapeutics Committee**: ~~2/16/2023;~~ **3/21/2024**
**REVISED/UPDATED/REFORMATTED:** ~~3/9/2023; 4/26/2024; 6/13/2025;~~ **7/1/2026**