SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Oxlumo® (lumasiran)

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:** _____

Recommended Dosage:

Oxlumo		
Body Weight	**Loading Dose**	**Maintenance Dose**
Less than 10 kg	6 mg/kg once monthly for 3 doses	3 mg/kg once monthly, beginning 1 month after the last loading dose
10 kg to less than 20 kg	6 mg/kg once monthly for 3 doses	6 mg/kg once every 3 months (quarterly), beginning 1 month after the last loading dose
20 kg and above	3 mg/kg once monthly for 3 doses	3 mg/kg once every 3 months (quarterly), beginning 1 month after the last loading dose

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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 has not had a liver transplant
- ❑ Medication will not be used in combination with other urinary oxalate reducing agents
- ❑ Member has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as confirmed 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

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 has an absence of unacceptable toxicity from the drug
- ❑ Member is being continuously monitored for beneficial response to therapy

Medication being provided by Specialty Pharmacy - PropriumRx

*****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 Therapeutic Committee:** 3/21/2024
***UPDATED/REVISED/REFORMATTED:** ~~4/26/2024, 6/13/2025;~~ **6/29/2026**