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: Rivfloza™ (nedosiran)

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:

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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Quantity Limits:

- 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

- ❑ 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 severe 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

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;~~ **7/1/2026**