

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**

**DUR MEDICATION RIVFLOZA™ (nedosiran)**

**Fax back to: 1-855-799-2553)**

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If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

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Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page).*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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**For initial approval, complete the following questions to receive a 6-months approval:**

1. Is the prescriber a specialist in genetics, nephrology or urology or the prescriber has consulted with a specialist in genetics, nephrology or urology?  
 Yes       No
2. Is the member 2 years of age or older?  
 Yes       No
3. Does the member have a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following:
  - Member has a biallelic pathogenic mutation in the alanine: glyoxylate aminotransferase (AGXT) gene as identified on molecular genetic testing; **OR**
  - Identification of alanine: glyoxylate aminotransferase (AGT) enzyme deficiency on liver biopsy? Yes       No
4. Does the member have a baseline for  $\geq 1$  of the following:
  - Urinary oxalate excretion level (corrected for BSA)
  - Spot urinary oxalate: creatinine ratio
  - Estimated glomerular filtration rate (eGFR)
  - Plasma oxalate level? Yes       No
5. Does the member have renal impairment defined as an estimated glomerular filtration rate (eGFR)  $< 30$  mL/min/1.73 m<sup>2</sup>?  
 Yes       No
6. Has the member received a kidney or liver transplant?  
 Yes       No
7. Does the prescriber attest that Rivfloza will not be used in combination with other urinary oxalate reducing agents (e.g., lumasiran)?  
 Yes       No

*(Form continued on next page).*

Member's Last Name:

Member's First Name:

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**For renewal, complete the following questions to receive a 1-year approval:**

8. Does the member continue to meet the above criteria (questions 1 through 7)?

Yes       No

9. Does the member continue to experience clinical benefit from the requested treatment?

Yes       No

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.