Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Oxlumo
(lumasiran)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Oxlumo 94.5 mg/0.5ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:
What is the patient's body weight?

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ PANTHERx
☐ Retail pharmacy
☐ Other (please specify):
☐ Hospital Outpatient
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test results, etc.) be attached with this request****

What is the diagnosis related to use:
☐ Primary Hyperoxaluria Type 1 (PH1)
☐ Primary Hyperoxaluria Type 2 (PH2)
☐ Primary Hyperoxaluria Type 3 (PH3)
☐ Other (please specify) _____

Will the patient use the requested drug concurrently with Rivfloza (nedosiran subcutaneous injection)? ☐ Yes ☐ No

if yes or unknown) Please provide the rationale for concurrent use.

Has the patient previously received a liver transplant for Primary Hyperoxaluria Type 1? ☐ Yes ☐ No

Is this initial or is the patient currently receiving Oxlumo?
☐ Initial Therapy
☐ Currently Receiving Oxlumo

(if Currently Receiving Oxlumo) Is documentation being provided that the patient is continuing to derive benefit from Oxlumo, according to the prescriber? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if no or unknown) Please provide support for continued use.

(if Initial Therapy) Is documentation being provided that the patient has had a genetic test confirming the diagnosis of Primary Hyperoxaluria Type 1 via identification of biallelic pathogenic variants in the alanine:glyoxylate aminotransferase gene (AGXT)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if Initial Therapy) Is documentation being provided that the patient has a urinary oxalate excretion of at least 0.5 mmol/24 hours/1.73 meters2 with the absence of secondary sources of oxalate? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has a urinary oxalate:creatinine ratio above the age-specific upper limit of normal? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has a plasma oxalate level at least 20 µmol/L? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if Initial Therapy) Is Oxlumo being prescribed by, or in consultation with, a nephrologist or urologist? ☐ Yes ☐ No

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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