HUSKY Health Program Oxlumo® (lumasiran)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information			
Member ID #:		Member Name (Last, First):	
DOB:	Sex:	Primary Diagnosis Code:	HCPCS Code:
Address:		City, State, Zip:	
From Date of Service:		To Date of Service:	
Total Number of Doses:		Number of Units per Dose:	
Please indicate the type of request: ☐ Initial Request ☐ Reauthorization Request			

Initial Authorization Requests: Please fill out completely for all **initial** requests.		
1. Does the individual have a diagnosis of Primary Hyperoxaluria Type 1 (PH1)? ***Please attach genetic testing results or results of liver biopsy.***	◯Yes	◯No
2. Does the individual have at least ONE of the following clinical signs or symptoms of PH1? ***Please mark "yes" for all that apply, and attach pertinent lab work.***	◯Yes	◯No
a. Elevated urine oxalate excretion (body surface area-normalized daily urine oxalate excretion output ≥ 0.7 mmol/1.73 m^2)?	◯Yes	◯No
b. Elevated plasma oxalate concentration > 20 µmol/L or > 1.76 mg/L?	◯Yes	◯No
c. Urine oxalate excretion to creatinine ratio above age-specific upper limit of normal?	◯Yes	◯No
3. Is Oxlumo® prescribed by, or in consultation with, a nephrologist, urologist, or an expert in the treatment of PH1? ***If yes, please specify:*** Provider Name: _____ Phone Number: _____	◯Yes	◯No
4. Will Oxlumo® be used in combination with nedosiran (RIVFLOZA®)?	◯Yes	◯No
5. Has the individual had a liver transplant?	◯Yes	◯No
6. Will Oxlumo® administration follow all current FDA-approved labeling for dosing and administration?	◯Yes	◯No

Reauthorization Requests: Please fill out completely for all **reauthorization** requests.		
1. Is the individual currently receiving treatment with Oxlumo®?	◯Yes	◯No
2. Has at least ONE of the following clinical signs or symptoms of PH1 decreased or normalized since initiation of therapy with Oxlumo®? ***Please mark "yes" for all that apply, and attach pertinent lab work.***	◯Yes	◯No
a. Urinary oxalate excretion level	◯Yes	◯No
b. Plasma oxalate level	◯Yes	◯No
c. Urine oxalate excretion: creatinine ratio	◯Yes	◯No
3. Is the individual currently taking nedosiran (RIVFLOZA®)?	◯Yes	◯No
4. Will Oxlumo® administration follow all current FDA-approved labeling for dosing?	◯Yes	◯No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	
Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner-signed order is on file. This form, and any statement on my letterhead attached hereto, has been completed by me or by my employee, and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: