Oxlumo

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** _________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Oxlumo SGM 4395-A – 04/2023.

Criteria Questions:

What is the ICD-10 code? __________

1. What is the diagnosis?

❒ Primary hyperoxaluria type (PH1), *Continue to 2*

❒ Other, please specify. _________________________, *Continue to 2*

2. Does the patient have a documented diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by either of the following? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) for molecular genetic tests showing a mutation in the alanine: glyoxylate aminotransferase (AGXT) gene or a liver enzyme analysis demonstrating absent or significantly reduced alanine: glyoxylate aminotransferase (AGT) activity. a) Molecular genetic test showing a mutation in the alanine: glyoxylate aminotransferase (AGXT) gene, b) Liver enzyme analysis demonstrating absent or significantly reduced alanine: glyoxylate aminotransferase (AGT) activity.

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the patient currently receiving treatment with the requested drug?

❒ Yes, *Continue to 4*

❒ No, *No Further Questions*

4. Has the patient's urinary and/or plasma oxalate decreased or normalized since initiation of therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

❒ Unknown, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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