TRICARE Prior Authorization Request Form for
nedosiran **(Rivfloza)**

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 12 months. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for requested medication.*	☐ **Yes** (subject to verification) **proceed to question 2**	☐ **No** **proceed to question 3**
2. Has the patient had disease stabilization or improvement in disease on therapy?	☐ **Yes** (subject to verification) **Sign and date below**	☐ **No** **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by genetic testing of the AGXT mutation?	☐ **Yes** **proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a nephrologist or urologist?	☐ **Yes** **proceed to question 5**	☐ **No** **STOP** **Coverage not approved**
5. Is the requested medication prescribed for an FDA-approved age?	☐ **Yes** **proceed to question 6**	☐ **No** **STOP** **Coverage not approved**
6. Does the patient have an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m2?	☐ **Yes** **proceed to question 7**	☐ **No** **STOP** **Coverage not approved**

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7. Has the patient tried pyridoxine?	☐ **Yes** **proceed to question 8**	☐ **No** **proceed to question 9**
8. Has the patient experienced an inadequate response or intolerance to pyridoxine?	☐ **Yes** **proceed to question 10**	☐ **No** **proceed to question 9**
9. Does the patient have a contraindication to pyridoxine?	☐ **Yes** **proceed to question 10**	☐ **No** **STOP** **Coverage not approved**
10. Will the requested medication be used in combination with Oxlumo?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Sign and date below**

STEP 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____

[14 August 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: