

RIVFLOZA

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Primary hyperoxaluria type 1 (PH1) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
1. Is the patient currently being treated with the requested agent?..... Yes No
 2. Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
 If yes, please specify FDA labeled contraindications: _____
 3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, geneticist, nephrologist, urologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
 4. Will the requested agent be used in combination with another urinary oxalate reducing agent (e.g., lumasiran)? Yes No
 5. Does the patient have an estimated GFR (eGFR) greater than or equal to 30 mL/min/1.73²? Yes No
 6. Has the patient received a liver transplant?..... Yes No
 7. Was the patient's diagnosis confirmed by one of the following: 1) genetic testing of the AGXT gene indicates a pathogenic mutation, or 2) liver biopsy demonstrates absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity?..... Yes No
 8. Is the requested agent being used to lower urinary oxalate levels?..... Yes No
 9. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
 10. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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11. Does the patient have hypocitraturia, elevated urinary supersaturation of calcium oxalate, or increasing stone burden? Yes No
 If yes, has the patient tried and had an inadequate response to potassium citrate or sodium citrate? Yes No
 If no, does the patient have an intolerance or hypersensitivity to potassium citrate or sodium citrate therapy? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to BOTH potassium citrate AND sodium citrate? Yes No
 If yes, please specify FDA labeled contraindications: _____

12. Does the patient have an AGXT mutation known to be unresponsive to therapy with pyridoxine (vitamin B6)? .. Yes No
 If no, has the patient tried and had an inadequate response to pyridoxine (vitamin B6) for at least 3 months? Yes No
 If yes, was the patient unresponsive to pyridoxine (vitamin B6)? Note: unresponsive is defined as less than or equal to 30% decrease in urine oxalate after 3 months of treatment with maximally tolerated pyridoxine..... Yes No
 If no, was the patient responsive to pyridoxine (vitamin B6)? Note: responsive is defined as a greater than 30% decrease in urine oxalate after 3 months of treatment with maximally tolerated pyridoxine. ... Yes No
 If yes, will the patient continue treatment with pyridoxine (vitamin B6) in combination with the requested agent? Yes No
 If no, does the patient have an intolerance or hypersensitivity to pyridoxine (vitamin B6) therapy? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to pyridoxine (vitamin B6)? Yes No
 If yes, please specify FDA labeled contraindications: _____

For renewal requests:

13. Has the patient had clinical benefit with the requested agent (e.g., decrease in urinary oxalate levels)? Yes No
14. Does the patient have an AGXT mutation known to be unresponsive to therapy with pyridoxine (vitamin B6)? .. Yes No
 If no, will the patient continue treatment with pyridoxine (vitamin B6) in combination with the requested agent? Yes No
 If no, was the patient unresponsive to pyridoxine (vitamin B6)? Note: unresponsive is defined as less than or equal to 30% decrease in urine oxalate after 3 months of treatment with maximally tolerated pyridoxine..... Yes No
 If no, does the patient have an intolerance or hypersensitivity to pyridoxine (vitamin B6) therapy? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to pyridoxine (vitamin B6)? Yes No
 If yes, please specify FDA labeled contraindications: _____

Please fax or mail this form to:
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 Clinical Review Department
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TOLL FREE

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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
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