BlueCross BlueShield Federal Employee Program

RIVFLOZA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Rivfloza (nedosiran)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑ Brand ❑ Generic

1. Does the patient have a diagnosis of primary hyperoxaluria type 1 (PH1)? ❑Yes ❑No

2. Will the patient be dosed based on actual body weight? ❑Yes ❑No

3. Has the patient received a liver transplant? ❑Yes ❑No

4. Does the patient have an estimated glomerular filtration rate (eGFR) greater than 30 milliliters per minute per 1.73 square meter? ❑Yes ❑No

5. Has the patient been on Rivfloza continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Does the prescriber agree to monitor urinary oxalate levels? ❑Yes ❑No

   b. Has the patient's diagnosis been confirmed by identification of biallelic pathogenic variants in alanine: glyoxylate aminotransferase (AGT or AGXT) gene OR liver biopsy demonstrating AGT deficiency? ❑Yes ❑No

   c. Does the patient have an elevated urine oxalate excretion level equal to or greater than 0.7 millimoles per 1.73 square meter? ❑Yes ❑No*

   ***If NO**, does the patient have an elevated plasma oxalate concentration level greater than 20 micromoles per liter or greater than 1.76 milligrams per liter? ❑Yes ❑No*

   ***If NO**, does the patient have a urine oxalate excretion to creatinine ratio above their age-specific upper limit of normal? ❑Yes ❑No

   d. Is this medication being prescribed by or in consultation with a nephrologist, urologist, geneticist, or any healthcare provider with expertise in treating primary hyperoxaluria type 1? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has the patient had a clinically meaningful response to therapy from pre-treatment baseline? Clinically meaningful response includes: decreased urinary oxalate concentrations, decreased urinary oxalate:creatinine ratio, decreased plasma oxalate concentrations, improvement, stabilization or slowed worsening of nephrocalcinosis, renal stone events, renal impairment, or systemic calcinosis. ❑Yes ❑No