Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Oxlumo
(lumasiran)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Adakveo 100mg/10ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test results, etc.) be attached with this request****

What is the diagnosis related to use:
☐ Primary Hyperoxaluria Type 1 (PH1)
☐ Primary Hyperoxaluria Type 2 (PH2)
☐ Primary Hyperoxaluria Type 3 (PH3)
☐ Post liver transplant
☐ Other (please specify) ___________________

Does the patient have a genetic test confirming an AGXT mutation? ☐ Yes ☐ No/Unknown
(If no or unknown) Did the patient have a liver biopsy demonstrating absent, or significantly reduced alanine glyoxylate aminotransferase (AGT) activity? ☐ Yes ☐ No/Unknown

Does the patient have a urinary oxalate level of at least 0.7mmol/24hrs/1.73 meters squared? ☐ Yes ☐ No/Unknown
(if no or unknown) Does the patient have an elevated urinary oxalate/creatinine ratio above the laboratory's age-specific normal reference range? ☐ Yes ☐ No/Unknown

Is Oxlumo being prescribed by, or in consultation with, a nephrologist, urologist, or medical geneticist? ☐ Yes ☐ No/Unknown
(if continuation of therapy) Is there a documented reduction in urinary oxalate excretion? ☐ Yes ☐ No/Unknown
(if continuation of therapy) Is there a documented reduction is the urinary oxalate/creatinine ratio? ☐ Yes ☐ No/Unknown
(if continuation of therapy) Is there a documented reduction in plasma oxalate levels from baseline? ☐ Yes ☐ No/Unknown

(if continuation of therapy) Is there documentation of improved or stabilized clinical signs and symptoms of Primary Hyperoxaluria Type 1? (for example nephrocalcinosis, formation of renal stones, renal impairment) ☐ Yes ☐ No/Unknown

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**______________________

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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