US Family Health Plan
Prior Authorization Request Form for
Nedosiran (Rivfloza)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after 12 months. For renewal of therapy an initial 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**

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 _____