



# Oxlumo™ (lumasiran) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate:  Start of treatment: Start date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Continuation of therapy, Date of last treatment \_\_\_\_/\_\_\_\_/\_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs			Patient Height: ____ inches or ____ cms		Allergies:

### B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Nephrologist <input type="checkbox"/> Other: _____					

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: (Patient selected choice)	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

### E. PRODUCT INFORMATION

Request is for: Oxlumo (lumasiran) Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

### F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code:  \_\_\_\_\_ Secondary ICD Code: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

### G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For All Requests (clinical documentation required):**

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

Yes  No Is this infusion request in an outpatient hospital setting?

Yes  No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes  No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes  No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?  
    Please provide a description of the behavioral issue or impairment: \_\_\_\_\_

Yes  No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
    Please provide a description of the condition:  Cardiovascular: \_\_\_\_\_  
     Respiratory: \_\_\_\_\_  
     Renal: \_\_\_\_\_  
     Other: \_\_\_\_\_

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

Yes  No Was the diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by a molecular genetic test confirming a mutation in the alanine?

→ Please select which genetic test was performed:  Glyoxylate aminotransferase (AGXT) gene  
 Liver enzyme analysis demonstrating absent or significantly reduced alanine: glyoxylate aminotransferase (AGT) activity

Please provide the patient's pretreatment estimated glomerular filtration rate (eGFR): \_\_\_\_\_

**For Continuation Requests (clinical documentation required):**

Yes  No Has the patient's urinary oxalate excretion decreased or normalized since initiation of therapy?

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.