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: ☐ Oxlumo 94.5 mg/0.5ml vial ICD10:

Directions for use: Dose: Quantity: Duration of therapy:
What is the patient's body weight?

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ PANTHERx
☐ Retail pharmacy
☐ Other (please specify):
☐ Hospital Outpatient
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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) __________________

Has the patient undergone genetic testing that confirmed biallellic pathogenic variants in the AGXT gene? ☐ Yes ☐ No
(If no) Did the patient have a liver biopsy demonstrating absent, or significantly reduced alanine glyoxylate aminotransferase (AGT) activity? ☐ Yes ☐ No

Prior to starting this drug, did/does the patient have a urinary oxalate level of at least 0.7 mmol/24 hours/1.73 meter2? ☐ Yes ☐ No

(if no) Prior to starting this drug, did/does the patient have an elevated urinary oxalate/creatinine ratio above the laboratory's age-specific normal reference range? ☐ Yes ☐ No

(if no) Prior to starting this drug, did/does the patient have a plasma oxalate level at least 20 micromoles (µmol)/L? ☐ Yes ☐ No

Is Oxlumo being prescribed by, or in consultation with, a nephrologist, urologist, or medical geneticist? ☐ Yes ☐ No

(if continuation of therapy) Has the patient had a documented reduction in urinary oxalate excretion? ☐ Yes ☐ No
(if continuation of therapy) Has the patient had a documented reduction in urinary oxalate/creatinine ratio? ☐ Yes ☐ No
(if continuation of therapy) Has the patient had a documented reduction in plasma oxalate levels from baseline? ☐ Yes ☐ No
(if continuation of therapy) Does the patient have documentation of improved, or stabilized clinical signs/symptoms of Primary Hyperoxaluria Type 1 (for example, nephrocalcinosis, formation of renal stones, renal impairment)? ☐ Yes ☐ No

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:**____________________

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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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