Louisiana Medicaid
Nedosiran (Rivfloza™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for nedosiran (Rivfloza™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient has a diagnosis of primary hyperoxaluria type 1 (PH1); **AND**
- The diagnosis has been confirmed by **ONE** of the following: (must be **stated on the request**)
    - Genetic testing demonstrating mutation in the alanine:glyoxylate aminotransferase (AGXT) gene; **OR**
    - Liver biopsy demonstrating significantly decreased or absent alanine:glyoxylate aminotransferase (AGT) enzyme activity; **AND**
- The recipient is 9 years of age or older on the date of the request; **AND**
- The recipient has a baseline eGFR $\geq$ 30 mL/min/1.73 m^2 within the previous 3 months (Date and results must be **stated on the request**); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a nephrologist, urologist, or geneticist; **AND**
- The recipient has not received a liver transplant (must be **stated on the request**); **AND**
- If request is for a non-preferred agent **– ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The recipient has not received a liver transplant (must be **stated on the request**); **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

References

Cochat P, Hulton SA, Acquaviva C, et. al. Primary hyperoxaluria Type 1: indications for screening and guidance for diagnosis and treatment. Nephrol Dial Transplant. 2012 May;27(5):1729-36.

Rivfloza (nedosiran) [package insert]. Plainsboro, NJ: Dicerna Pharmaceuticals, Inc; September 2023. https://www.novo-pi.com/rivfloza.pdf

UpToDate: Primary hyperoxaluria. Current through September 2022. www.uptodate.com

Revision / Date	Implementation Date
Policy Created / February 2024	July 2024