Pharmacy Drug Policy Checklist

POLICY NAME	Policy #:	POLICY #	The purpose of this policy is to define coverage criteria for Oxlumo (lu

Criteria

Coverage Criteria

- ☐ **1.1** Documented diagnosis of primary hyperoxaluria type 1 based on both of the following:
  - Confirmed genetic testing of AGXT or AGT mutation
  - Metabolic testing demonstrating ONE of the following: o Increased urinary oxalate excretion (greater than 1 mmol/1.73m2 per day [90mg/1.73m2 per day], increased urinary oxalate:creatinine ratio relative to normative values for age); OR o Increased plasma oxalate and glyoxylate concentrations
- ☐ **1.2** Patient does not have a history of liver or kidney transplant
- ☐ **1.3** Patient has tried pyridoxine for at least 3 months with no significant improvement
- ☐ **1.4** Ordered by, or in consultation with a nephrologist (kidney doctor) or urologist (doctor of the urinary tract) or medical gene doctor
- ☐ **1.5** Review of chart notes documenting diagnosis and confirming that patient has met all above requirements for treatment with Oxlumo by both a pharmacist and medical director