

PRIOR AUTHORIZATION POLICY

POLICY: Metabolic Disorders – Primary Hyperoxaluria Medications – Rivfloza Prior Authorization Policy

- Rivfloza™ (nedosiran subcutaneous injection – Novo Nordisk)

REVIEW DATE: 11/22/2023

OVERVIEW

Rivfloza, a lactate dehydrogenase A-directing (LDHA) small interfering RNA, is indicated for the treatment of **primary hyperoxaluria type 1 (PH1)** to lower urinary and plasma oxalate levels in adults and children ≥ 9 years of age with relatively preserved kidney function.¹

Disease Overview

Primary hyperoxaluria type 1 is a rare autosomal recessive inborn error of glyoxylate metabolism that results in the overproduction of oxalate, which forms insoluble calcium oxalate crystals that accumulate in the kidney and other organs, leading to issues such as nephrocalcinosis, formation of renal stones, and renal impairment.² Mutations in the alanine:glyoxylate aminotransferase gene (AGXT) cause primary hyperoxaluria type 1.³ Liver transplantation is the only curative intervention for primary hyperoxaluria type 1 as it corrects the underlying enzymatic defect due to mutations of the AGXT gene.^{2,4}

Clinical Efficacy

The efficacy of Rivfloza for the treatment of primary hyperoxaluria type 1 has been evaluated in one pivotal study.^{1,5} The study included patients ≥ 9 years of age with genetically confirmed PH1 and urinary oxalate excretion ≥ 0.7 mmol/24 hr/1.73 m². An ongoing open-label extension trial is following patients for up to 4 years.⁶ The primary efficacy endpoint of the area under the curve (AUC) percent change from baseline in 24-hour urinary oxalate excretion was assessed following 6 months of Rivfloza therapy.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Rivfloza. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Rivfloza as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Rivfloza to be prescribed by or in consultation with a physician who specializes in the condition being treated. All reviews will be forwarded to the Medical Director for evaluation.

Documentation: Documentation is required for use of Rivfloza as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Subsequent coverage reviews for a patient who has previously met the documentation requirements and related criteria in the Rivfloza *Prior Authorization Policy* through the Coverage Review Department, and who is requesting reauthorization, are NOT required to re-submit documentation for reauthorization, except for the criterion requiring documentation of a continued benefit from Rivfloza therapy.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Rivfloza is recommended in those who meet the following criteria:

FDA-Approved Indication

1. Primary Hyperoxaluria Type 1. Approve Rivfloza for the duration noted if the patient meets one of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets the following (i, ii, iii, iv, v, and vi):

i. Patient is ≥ 9 years of age; AND

ii. Patient has had a genetic test confirming the diagnosis of Primary Hyperoxaluria Type 1 via identification of an alanine:glyoxylate aminotransferase gene (AGXT) mutation **[documentation required]**; AND

iii. Patient has an estimated glomerular filtration rate (eGFR) ≥ 30 ml/min per 1.73 m² **[documentation required]**; AND

iv. Patient meets ONE of the following (a, b, or c):

a) Patient has a urinary oxalate excretion ≥ 0.7 mmol/24 hours/1.73 meters² **[documentation required]**; OR

b) Patient has a urinary oxalate:creatinine ratio above the age-specific upper limit of normal **[documentation required]**; OR

c) Patient has a plasma oxalate level ≥ 20 μ mol/L **[documentation required]**; AND

v. Patient has not previously received a liver transplant for Primary Hyperoxaluria Type 1; AND

vi. The medication is prescribed by or in consultation with a nephrologist or urologist.

B) Patient is Currently Receiving Rivfloza. Approve for 1 year if, according to the prescriber, the patient is continuing to derive benefit from Rivfloza as determined by the most recent (i.e., within the past 6 months) objective measurement **[documentation required]**.

Note: Examples of objective measurements of a response to Rivfloza therapy are reduced urinary oxalate excretion, decreased urinary oxalate:creatinine ratio, or reduced plasma oxalate levels from baseline (i.e., prior to Rivfloza therapy) or improved or stabilized clinical signs/symptoms of Primary Hyperoxaluria Type 1 (e.g., nephrocalcinosis, formation of renal stones, renal impairment).

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Rivfloza is not recommended in the following situations:

1. Primary Hyperoxaluria Type 2 (PH2). Rivfloza may have benefit in PH2; however, the efficacy and safety of Rivfloza in patients with PH2 have not been established. Clinical trials are ongoing.

2. Primary Hyperoxaluria Type 3 (PH3). Rivfloza may have benefit in PH3; however, the efficacy and safety of Rivfloza in patients with PH3 have not been established. Clinical trials are ongoing.

3. Primary Hyperoxaluria with end stage renal disease (ESRD). Rivfloza may have benefit in patients with PH1 or PH2 and ESRD; however, the efficacy and safety of Rivfloza in this patient population have not been established. Clinical trials are ongoing.

4. Concurrent use of Rivfloza with Oxlumo (lumasiran subcutaneous injection). Oxlumo is another small interfering RNA agent and should not be used with Rivfloza.

5. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Rivfloza™ subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; September 2023.
2. Milliner DS, Harris PC, Sas DJ, et al. Primary Hyperoxaluria Type 1. Gene Reviews® Available at: <https://www.ncbi.nlm.nih.gov/books/NBK1283/#:~:text=In%20primary%20hyperoxaluria%20type%201,deposit%20in%20the%20renal%20parenchyma>. Updated February 10, 2022. Accessed on October 3, 2023.
3. Primary Hyperoxaluria: MedlinePlus Genetics. U.S. National Library of Medicine; National Institutes of Health; Department of Health and Human Services. Available at: <https://medlineplus.gov/genetics/condition/primary-hyperoxaluria/#resources>. Accessed on October 3, 2023.
4. Cochat P, Rumsby G. Primary hyperoxaluria. *N Engl J Med*. 2013;369(7):649-658.
5. Baum MA, Langman C, Cochat P, et al. PHYOX2: a pivotal randomized study of nedosiran in primary hyperoxaluria type 1 or 2. *Kidney Int*. 2023;103(1):207-217.
6. Hoppe B, Coenen M, Schalk G, et al. Nedosiran in primary hyperoxaluria subtype 1: interim results from an open label extension trial (PHYOX3) [poster]. Presented at: 19th International Pediatric Nephrology Association (IPNA) Congress. Calgary, Canada. September 7-11, 2022.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy		11/22/2023