

Oxlumo (lumasiran)
Effective 06/05/2023

Plan	<input checked="" type="checkbox"/> MassHealth UPPL <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Exceptions	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Overview

Oxlumo® (lumasiran) is a hydroxyacid oxidase 1 (HAO1)-directed small interfering ribonucleic acid (siRNA) indicated for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels in pediatric and adult patients.

No PA	Require PA
	Oxlumo®(lumasiran) ^{PD}

PD=preferred drug. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization will be granted when all the following criteria has been met, and documentation has been submitted:

1. Diagnosis of primary hyperoxaluria type 1
2. Prescriber is a specialist (e.g., nephrologist) or consult notes from a specialist's office are provided
3. Results from genetic testing showing mutations in the AGXT gene
4. Member's current weight (use to verify correct dosing)
5. Appropriate dosing

New members who are stable on Oxlumo® (lumasiran) can be approved after meeting reauthorization criteria.

Continuation of Therapy

Reauthorization by physician will need to meet the following criteria:

1. Documentation of positive response to therapy
2. Updated member weight (use to verify correct dosing)
3. Appropriate dosing

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.

References

1. Lumasiran® [package insert on the internet]. Cambridge (MA): Alnylam, Inc.; 2020 Nov [cited 2021 Dec 20]. Available from: <https://www.oxlumo.com/>.
2. National Organization for Rare Disorders. Primary hyperoxaluria [webpage on the Internet]. Danbury (CT): National Organization for Rare Disorders; 2020 [cited 2021 Mar 2]. Available from: <https://rarediseases.org/rare-diseases/primary-hyperoxaluria>.
3. Niaudet P. Primary hyperoxaluria. In: Mattoo TK (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Dec 20]. Available from: <http://www.utdol.com/utd/index.do>.

Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL. Created criteria to be in compliance with Masshealth unified formulary requirements (Effective 4/1/23).

05/10/23 – Reviewed and updated for P&T. Approval duration as been changed to 12 months. Effective 6/5/23.

