

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

KrystexxaTM (pegloticase)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

KrystexxaTM 8mg/mL **Dose:** _____ **Start Date:** _____

BILLING INFORMATION

Place of administration:

Provider's Office
 Other: _____

Billing Options:

Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT
Authorization for Krystexxa™ (pegloticase) requires the following information to certify:

Patient must have one of the following diagnoses (step therapy and additional requirements listed below individual indication):

1. Treatment-failure gout (TFG) **ICD code:** _____

Patient has symptomatic gout and has experienced three or more flares within the past 18 months.

Patient has at least one gout tophus *or* has gouty arthritis

Krystexxa has not been studied in patients with the following conditions. Authorization will not be given in patients with these conditions. *Please check which, if any, apply:*

Unstable angina

Uncontrolled arrhythmia

Non-compensated heart failure (CHF)

Uncontrolled hypertension (e.g. > 150/95 mmHg)

Dialysis

Recipient of organ transplant

Pregnancy

Glucose-6-phosphate dehydrogenase (G6PD) deficiency

Therapeutic trial (at least 6 months) and clinical failure of **both** of the following for maintenance treatment of gout, at maximum doses (e.g. allopurinol 900 mg per day). Clinical failure is defined as the inability to maintain serum uric acid (SUA) level \leq 6 mg/dL after 6 months of maintenance therapy.

allopurinol Dose: _____ Dates: _____

Uloric (febuxostat) Dose: _____ Dates: _____

If patient has contraindication to allopurinol, probenecid is an alternative:

probenecid Dose: _____ Dates: _____

Please provide the patient's serum uric acid (SUA) levels:

SUA level: _____ mg/dL Date: _____

SUA level: _____ mg/dL Date: _____

Patient will receive appropriate prophylactic treatment for anaphylaxis and infusion reactions in accordance with the recommendations from the FDA and the Krystexxa REMS program

For Continuation Therapy:

Continuation therapy (beyond 3 months initial coverage) requires the patient to achieve a SUA level \leq 6 mg/dL (include documentation with request)

2. OTHER: _____ **ICD code:** _____

Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

DURATION OF THERAPY

If approved, initial authorization will be for one dose every two weeks for three months. Continued authorization beyond three months will be granted in 12 month authorization periods for patients who respond to initial therapy (defined as a SUA \leq 6 mg/dL at month 3).

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

***** All fields must be complete and legible for Prior Authorization Review*****
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX