Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Crysvita® (burosumab-twza)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Crysvita 10 mg/mL
- ☐ Crysvita 20 mg/mL
- ☐ Crysvita 30 mg/mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:
- ☐ Physician's office
- ☐ Outpatient infusion
  - Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  - Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  - Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Drug cost information

The wholesale acquisition cost for Crysvita® is up to $10,200.00 per vial. Annual treatment costs will vary depending on the patient's weight, but can approach $795,600.00.

All fields must be complete and legible for review. Your office will receive a response via fax.

New 06/2018
Last reviewed 07/2018

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for the treatment of X-linked hypophosphatemia (XLH)
   Diagnosis must be confirmed by:
   - Genetic testing (PHEX-gene mutation), OR
   - Serum fibroblast growth factor-23 (FGF23) level > 30 pg/mL
2. Must be age 1 or older
3. Must have baseline serum phosphorus level below lower limit of laboratory reference range with current hypophosphatemia
4. Must have clinical signs and symptoms of XLH (e.g. rickets, growth retardation, musculoskeletal pain, bone fractures, etc.)

When the above criteria is met, initial approval of Crysvita® will be for 12 months.

For continuation, patient must meet the following requirements:

1. The patient is compliant in taking the medication as scheduled
2. Must have experienced normalization of serum phosphate while on therapy (documentation of laboratory levels must be submitted to Priority Health)
3. Must have experience a positive clinical response to therapy (e.g. enhanced height velocity, improvement in skeletal deformities, reduction in bone fractures)

When the above continuation criteria is met, approval of Crysvita® will be granted for no more than 12 months.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, 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.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ X-linked hypophosphatemia

Which of the following is provided to confirm the diagnosis (documentation must be submitted to Priority Health)?

☐ Genetic testing

☐ FGF23 serum level > 30 pg/mL

☐ Neither; Rationale for use:_____

_____

☐ Other – the patient's condition is: _____

Rationale for use: _____

B. What is the patient's serum phosphate level?_____ (lab report will reference range must be submitted to Priority Health)

C. Documentation of clinical signs and symptoms of XLH must be submitted to Priority Health.

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Has the patient been compliant with therapy?

☐ Yes

☐ *No; rationale for continued use:*_____

_____

B. Documentation of normalized serum phosphate levels must be submitted to Priority Health

All fields must be complete and legible for review. Your office will receive a response via fax.

New 06/2018
Last reviewed 07/2018

C. Documentation of improved clinical outcomes must be submitted to Priority Health

Additional information

When approved, the amount of Crysvita® allowed is limited to the FDA-approved dose and frequency.

Pediatrics

- Starting dose is 0.8 mg/kg of body weight, rounded to the nearest 10 mg, administered every two weeks.
- The minimum starting dose is 10 mg up to a maximum dose of 90 mg.
- Measure fasting serum phosphorus every 4 weeks for the first 3 months of treatment, and thereafter as appropriate. If serum phosphorus is above the lower limit of the reference range for age and below 5 mg/dL, continue treatment with the same dose.

Adults

- Starting dose is 1 mg/kg body weight, rounded to the nearest 10 mg up to a maximum dose of 90 mg, administered every four weeks.
- Assess fasting serum phosphorus on a monthly basis, measured 2 weeks post-dose, for the first 3 months of treatment, and thereafter as appropriate. If serum phosphorus is within the normal range, continue with the same dose.

Dosing of Crysvita® should not be adjusted more frequently than every 4 weeks and must be administered by a healthcare professional.

All fields must be complete and legible for review. Your office will receive a response via fax.
New 06/2018
Last reviewed 07/2018